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November 15, 2015

Attorney Betsy Garber
Disciplinary Counsel
Board of Professional Responsibility
10 Cadillac Drive, Suite 220
Brentwood, TN 37027

RE: File No: 37705-5-KB
Respondent: Matthew Michael Curley, #18613

Counsel for Defendant, The Brattleboro Retreat in the matter of
United States ex. rel. Thomas Joseph v. The Brattleboro Retreat
United States District Court, District of Vermont, Case No: 2:13-cv-55wks

Dear Attorney Garber:

As you are aware, I represent myself in the above captioned matter. I am submitting additional and new information, that I respectfully request be considered together with the already extensive analysis I have provided the TN BPR in my three (3) prior submissions dated 02/16/15, 08/02/15 and 09/17/15.

In the event anyone has any lingering doubts of Attorney Matthew M. Curley and his co-counsel's misconduct, this submission which contains significant new information as well as supplemental analysis of some prior examples provided to the TN BPR should remove any remaining doubt of Attorney Curley's and co-counsel's misconduct before the Court.

In many respects, much resolves around whether Attorney Matthew M. Curley with the help of his co-conspirator Attorney Elizabeth R. Wohl abused their right to use "persuasive force" in defense of their historic client and crossed a line to advance material misrepresentations of "fact" contained in the federal Complaint to fraudulently mislead the Court in violation of the Rules of Professional Conduct ("RPC") as set forth by the Supreme Court of Tennessee. When the body of evidence is considered in totality, the sheer number of misrepresentations (as compared to federal Complaint content) confirm that defense counsel had long ago abandoned any sense or obligation to promote justice as Officers of the Court in their pleadings before the Court.

In this submission, I would respectively ask the TN BPR to pay particular attention to the strategies highlighted below employed by defense counsel when the TN BPR considers the

larger body of evidence. The Retreat used a few transactional patterns that are often hard to identify so there are multiple ways to identify fraudulent activity and the Complaint contains the examples of many of those strategies. Regrettably, defense counsel crossed the line and repeatedly made assertions that were patently false or misrepresented, purposely, the written word of the federal Complaint. Often defense counsel would mislead the Court with subtle misrepresentations of the facts contained in the federal Complaint and also on a number of occasions went to great lengths to conceal and to avoid their obligation to return the amounts they were not entitled and identified in the Complaint.

One key strategy, is when defense counsel repeatedly asserted flat out lies that defied the written word of the federal Complaint, they replaced them with manufactured lies that the Complaint directly evidence. Therefore, the TN BPR should not take for face value anything defense counsel assert came from or was derived from the federal Complaint without cross referencing and double checking what the federal Complaint actually states because they more often than not, advance the direct opposite of what the federal Complaint actually stated or what my former attorneys asserted.

By defense counsel's own conceded knowledge of the Wartime Suspension of Limitations Act (WSLA) and the overwhelming body of "pertinent legal authorities" cited in my February 2015 submission and specifically those within the Second Circuit evidence defense counsel's misconduct in failing to provide the Court with their conceded knowledge of the WSLA to promote justice. By misleading the Court with bogus arguments while ignoring controlling case law and other pertinent legal authorities while conveying their conceded knowledge of the wartime statute demands that the Rules be enforced and Attorney Curley be held accountable. His misconduct and well evidenced misrepresentations before the Court led Judge William Sessions to jettison nearly 2/3 of all 32 patient examples as time barred - - - none of which should have been tossed out had it not been for defense counsel's affirmative misconduct and abandonment of their professional obligations to make the Court aware of their conceded knowledge of the WSLA based on controlling case law in the Second Circuit and other pertinent legal authorities.

Note to TN BPR: Pages 6 thru 8 of the federal Complaint provide an explanation of the posting codes used and referred in the federal Complaint where code 10 represents a payment; code 20 represents a contractual allowance; and code 21 represents the "allowance reversal" the defendant used to embezzle millions from virtually everyone they did business with.

⏩ **TN BPR**: MTD Page 1: Preliminary Statement:

Defense counsel state, "Mr. Joseph formerly worked at the Retreat as a Self-Pay Collections Representative. In other words, Mr. Joseph focused on collecting amounts owed by individual patients (described by Mr. Joseph as "patient responsibility") and not amounts owed by commercial or government payers."

The above assertion by defense counsel represent a material misrepresentation of the facts as set forth in the federal Complaint. Complaint ¶82 was crystal clear, "The position described to Relator involving calling self-payers, including individuals who have unpaid obligations to the Retreat pursuant to Medicare, Medicaid, or other government health care benefit programs rules regarding beneficiary deductibles and coinsurance payments, in an attempt to resolve unpaid claims and other claims-related issues."

Note to TN BPR: Instead of recognizing the facts contained in Complaint ¶82 that I did have responsibility for "patient balances" for **ALL** payers, defense counsel assert materially false and misleading assertions by the injection of the statement "and not amounts owed by commercial or government payers" which when compared to Complaint ¶82 demonstrate clearly the purposeful lies defense counsel asserted as identified in MTD Preliminary Statement on Page 1 that directly contradict the federal Complaint and specifically, Complaint ¶82.

TN BPR: MTD Page 6: III. The Complaint 2nd paragraph:

Defense counsel assert material misrepresentations of the facts contained in the federal Complaint when they state, "The Complaint alleges that the Retreat receives overpayments in the ordinary course of its business in providing medical services to patients. (*Id.* ¶70.) The Complaint does not allege any wrongdoing on the part of the Retreat in merely receiving an overpayment from a payer. (*Id.* ¶¶70-71.)"

Note to TN BPR: The Complaint paragraphs that defense counsel cite here to assert and support their material misrepresentations of the facts are very relevant to the underlying misconduct investigation now being considered by the TN BPR and specifically Complaint ¶71 which will evidence their misleading and erroneous assertions that "The Complaint does not allege any wrongdoing on the part of the Retreat in merely receiving an overpayment from a payer" which will be discussed further below.

TN BPR: Complaint ¶70: "The Retreat receives overpayments in the ordinary course of business. For example, an overpayment results when bills are sent to more than one insurance company for the same service rendered resulting in more than one insurer paying as the primary payer. An overpayment also occurs when Medicare is a primary payer for a patient but the patient has Medicaid as a secondary and Tricare or Champus as a tertiary payer, which causes Tricare or Champus to make an overpayment and thus to be entitled to a refund as the final payer."

TN BPR: Complaint ¶71: "Overpayments also occur when claims are billed to Medicaid, which duly pays the claims, and then the Retreat discovers subsequently that such patients also have Medicare or commercial insurance coverage, or when Medicare pays a claim and commercial insurance coverage for the same claim is subsequently discovered. Finally, overpayments occur when multiple claims for the same service and date of service are submitted to Medicare, Medicaid, Tricare, Champus, and/or commercial insurance.

Defense counsel's erroneous and material misrepresentations of the facts contained in the federal Complaint are revealed by reviewing the entire context and spoken word of the very Complaint paragraphs (especially Complaint ¶71) which defense counsel not only cite to support their false assertions noted previously but whose content they purposely gut as they carve out material facts contained in Complaint ¶71 to mislead the Court with their false assertions that "The Complaint does not allege any wrongdoing on the part of the Retreat in merely receiving an overpayment from a payer" when the written word of Complaint ¶5, ¶71, and ¶101 confirms without any doubt that defense counsel were manufacturing lies in their legal pleadings to perpetuate a fraud in a federal Court of law.

NOTE TO TN BPR: Defense counsel cite both Complaint ¶¶ 70-71 to justify their narrative highlighted above on MTD Page 6 to state "The Complaint does not allege any wrongdoing on the part of the Retreat in merely receiving an overpayment from a payer" and do not provide the Court with the full context of Complaint ¶71 nor do they acknowledge other federal Complaint paragraphs that speak to this issue in their collective effort to mislead the Court to erroneously project that the Retreat did nothing improper by merely receiving overpayments. This is not true and represents a significant and material misrepresentation of the facts as defense counsel fail to convey the full context of Complaint ¶71 which defense counsel deviously left out to buttress their misleading assertions highlighted above, which upon careful review, do not support their false and erroneous claims advanced in their pleadings before the Court. Indeed, Complaint ¶71 makes clear that the Retreat would proactively double bill to generate overpayments by using all discovered payers hence why the last sentence of Complaint ¶71 clearly states "Finally, overpayments occur when multiple claims for the same service and date of service are submitted to Medicare, Medicaid, Tricare, Champus, and/or commercial insurance."

In addition to Complaint ¶¶ 70-71 above, Complaint ¶101 also speaks to defense counsel's material misrepresentation of the facts contained on MTD Page 6 when defense counsel advance pure passive lies before the Court when they state, "The Complaint does not allege any wrongdoing on the part of the Retreat in merely receiving an overpayment from a payer" when Complaint ¶101 makes clear that the Retreat was engaging in misconduct to generate the very overpayments at issue and discussed on MTD Page 6.

➔ **TN BPR:** Complaint ¶101 reads as follows: "When the Retreat receives a partially paid claim from CMS, the Retreat recodes and resubmits all charges, including those for which payments have previously been received from CMS, and then resubmits the full claim, causing Medicare or Medicaid to make duplicate payments for the same services. This creates an overpayment credit in favor of Medicare or Medicaid."

And, if anyone isn't yet convinced of Attorney Matthew M. Curley and co-conspirator Attorney Elizabeth R. Wohl's material misrepresentation of the facts, defense counsel's fate and fraud

before the Court are driven home with stunning clarity when you review Complaint ¶5 below which couldn't be any clearer:

> *"The Retreat generates these overpayments by knowingly or with reckless disregard for the true state of affairs submitting duplicate claims for payment to health care benefit programs on the same dates of service, and by knowingly or with reckless disregard for their true state of affairs, receiving and retaining payments from health care benefit programs for which it did not have proper documentation and to which it was not entitled."*

Indeed, despite the unmistakable clarity contained in Complaint ¶5, Complaint ¶71 and Complaint ¶101 defense counsel assert misleading and false assertions that fly in the face of actual federal Complaint content where defense counsel are caught red-handled misleading the Court by multiple material misrepresentations of the facts by stating, "The Complaint does not allege any wrongdoing on the part of the Retreat in merely receiving an overpayment from a payer" which Complaint ¶5, ¶71 and ¶101 confirm were purposely asserted to mislead the Court and perpetuate a fraud in a federal Court of law.

TN BPR: MTD Page 7 1st Full Paragraph **(Part 1 of 3)**

Defense counsel state, "The Complaint includes allegations regarding 32 separate patient accounts, spanning roughly seven years, with respect to which it asserts that the Retreat used Code 21 to eliminate credits owed to federal and state payers. (*Id.* ¶¶ 104-173.) The Complaint does not identify any actual bills submitted to government payers by the Retreat or any reimbursement received by the Retreat from those payers. Rather, the entirety of the Complaint is based on inferences drawn from the use of accounting entries and codes on particular patient accounts and his review of patient ledgers…"

In response to the materially false and misleading statements on MTD page 7 highlighted above where Attorney Mathew M. Curley and co-conspirator Attorney Elizabeth R. Wohl fail to advance that the identity of the "bills" or claims preceded their use in the federal Complaint. The federal Complaint was merely transcribing those bills or claims into a written narrative format so that the Court could see the import of the fraudulent behavior that those very bills or claims defense counsel suggest were not identified. Indeed, the federal Complaint provided an extensive narrative of at least 32 patient "bills" or "claims" all of which were submitted to government or other payers. Contrary to defense counsel's false and erroneous assertions the federal Complaint clearly identified in numerous Complaint paragraphs the amounts received in reimbursement that only would have occurred if an actual claim or bill had been submitted for payment.

TN BPR: Complaint ¶105: Accordingly, the Retreat submitted a claim for payment for DOS 3/21/2006 for Patient 1 at a per diem amount equal to the allowed charges of $1,512.90 less the $952.00 deductible designated by Medicare Part A as patient responsibility, or $560.89.

➔ **TN BPR:** Complaint ¶106: Because Patient 1 was also an indigent Medicaid beneficiary, the Retreat submitted a claim for payment of his patient responsibility in the amount of $952.00 to Medicaid of Vermont. On April 20, 2006, the Retreat received $3,891.66 from Medicare Part A for Patient 1's inpatient per diem charges for DOS 3/21/2006. The April 20, 2006 payment resulted in an overpayment of $3,330.77, or $3,891.66 less than the $560.89 that Medicare Part A legitimately was required to pay, which, when reduced by the amount of $77.11 which the Retreat would normally write off as a discount to Medicare Part A, equals $3,253.66. The patient ledger reflects that when the Medicare Part A overpayment to the Retreat was posted on April 20, 2006 using posting code 10, a simultaneous entry using posting code 21 (signifying an allowance reversal) was posted in the amount of $3,253.66, eliminating the entire balance of the overpayment from the patient ledger.

➔ **TN BPR:** Complaint ¶107: On April 27, 2006, a payment of $952.00 from Medicaid of Vermont was posted to the per diem (service code 11000) line item for DOS 3/21/2006 for Patient 1, ostensibly as payment for the Medicare Part A deductible that would have been Patient 1's responsibility if he were not also a Medicaid beneficiary, or dual-eligible. On information and belief, these transactions were posted to DOS 3/21/2006 for Patient 1's account by Rose Dietz or another Retreat employee acting at the direction of Rob Simpson, John Blaha, Lisa Dixon, and/or Jennifer Broussard's instructions.

➔ **TN BPR:** Complaint ¶143: "In an instance involving the White Mountain Veterans Administration Medical Center (VA), **the Retreat has submitted bills** for "ad hoc" payment, or payment when there is not a pre-existing contract for services, to the VA, for which the Retreat agreed to a flat rate of $1,000.00 per diem for room and board excluding physician's charges, but which the VA inadvertently paid at a rate of $1,767.20 per diem for room and board in addition to paying at a rate of 74% to 94% of the Retreat's nominal charge for additional services (i.e., physician's charges, medical supplies, nursing care, etc.)."

➔ **TN BPR:** Complaint ¶144: "In total, the room and board for Patient 9's episode 2, spanning DOS 06/15/2009 to 06/22/2009, the Retreat nominally charged $1,880.00 for room and board for seven days (the patient was discharged on the eighth day, so there was no charge for room and board), plus the following: $209.00 in physician's charges for DOS 06/15/2009; $437.67 in physician's and other charges for DOS 06/16/2009; $195.53 in physician's and other charges for DOS 06/17/2009; $197.19 in physician's and other charges for DOS 06/18/2009; $396.56 in physician's and other charges for DOS 06/19/2009; no additional charges beyond room and board for DOS 06/20/2009 and 06/21/2009; and $130.00 in physician's charges for discharge care on DOS 06/22/2009, for a total nominal charge for the additional services in the amount of $1,565.95."

➔ **TN BPR:** Complaint ¶145: "The ledger, the attached cash reconciliation report document, and the follow-up notes report for this patient and episode show that the Retreat was paid, in addition to 94% of its nominal charges (with one exception for DOS 06/15/2009, which was

paid at only 74%) for services beyond room and board, 94% of its nominal charge for room and board, or $767.20 more for each DOS than the Retreat had agreed to accept as payment in full for room and board exclusive of physician's and other miscellaneous charges."

Note to TN BPR: Attached as **Exhibit B** are the Follow Up Notes for this client which Complaint ¶145 makes were VERY clear. Indeed, the Follow Up Notes which the federal Complaint stated included confirmation the Retreat was paid in excess of the $1,000/day "ad-hoc" agreement that was memorialized in Follow Up notes and referred in the federal Complaint contrary to defense counsel's material misrepresentation by its failure to acknowledge that Complaint ¶145 specified exactly what defense counsel asserts falsely doesn't exist.

➔ **TN BPR** Complaint: ¶146: "In sum, then, on December 30, 2009, the Retreat received payment from the VA in the amount of $155.51 for the physician's charges for DOS 06/15/2009, $1,275.53 for the physician's and other miscellaneous charges for DOS 06/16/2009 through 06/22/2009, and $12,370.40 for room and board for the entire DOS range encompassed by Patient 9's episode 2, for a total of $13,801.44. The $12,370.40 for room and board alone also represents 94% of the Retreat's nominal charge of $1,880.00 per day for seven days.

➔ **TN BPR** Complaint: ¶147: "Even assuming that it was proper for the VA to pay between 74% and 94% of the Retreat's nominal charges for the services it rendered besides room and board, because the Retreat had agreed by contract to charge only $1,000.00 per day for room and board to this particular patient, the payment of $13,801.44 it received from the VA represents and overpayment due and payable to the VA in the amount of $5,370.40."

➔ **TN BPR:** Complaint ¶149: In addition, the Retreat received a second payment from the VA for the same services and DOS that was posted on January 5, 2010 totaling $1,196.00. This amount represented the full amount of the nominal charge **billed** by the Retreat for physician's services only (i.e., exclusive of other miscellaneous charges and of charges for room and board) for all DOS in Patient 9's episode 2." (**Note to TN PRB:** In this one paragraph you can see the Retreat billed the VA with specific dates of service, level of care and charges and received payment in direct opposition to defense counsel's false and materially misleading assertions before the Court and contained on MTD page 7.)

➔ **TN BPR:** Complaint ¶151: As a further example involving Medicare Part A and a commercial insurance carrier that should have been and apparently **was eventually billed** as the primary payer, Patient 10's episode 3 ledger is instructive. There, Medicare Part A apparently originally would have paid $740.00 for per diem hospital inpatient services (service code 11000) for DOS 04/18/2005 for which the Retreat claimed a nominal charge of $1590.00, resulting in an entry posted on May 11, 2005 using code 20 (discount or allowance credit in favor of the payer) in the amount of $850.00.

➔ **TN BPR:** Complaint 153: Finally, there are two entries associates with service code 11000 on DOS 04/18/2005 that exactly offset each other, were posted on July 13, 2005 using code 10

and code 21, respectively, and are in the amount of $6,099.95. This very large overpayment was made by Medicare Part A, and the presence of the code 21 (reversal of a discount or allowance credit) means that the Retreat failed to report the existence of the overpayment and pocketed the cash instead. On information and belief, Rose Dietz performed the transactions discussed in the paragraph acting pursuant to Robert Simpson, John Blaha, Lisa Dixon, and/or Jennifer Broussard's instructions.

Note to TN BPR: Contrary to defense counsel's false assertions on MTD page 7 where they erroneously claim that the Complaint does not identify any "bills" to government payers or any reimbursement, please refer to Complaint ¶'s 105, 106, 107, 143-147, 149, 151 and 153 which represent a sampling of numerous Complaint paragraphs that overwhelmingly demonstrated the Complaint identified numerous bills/claims/charges to government payers and consistently demonstrated the amounts the Retreat received in payment which often represented overpayments - - which would not have occurred had the "bills" or claims referenced not been real or submitted for payment. Indeed, defense counsel again are caught advancing material misrepresentations of the very facts contained in the federal Complaint to mislead the Court and derail justice.

TN BPR: MTD Page 7 1st Full Paragraph **(Part 2 of 3)**

Defense counsel state, "The Complaint includes allegations regarding 32 separate patient accounts, spanning roughly seven years, with respect to which it asserts that the Retreat used Code 21 to eliminate credits owed to federal and state payers. (*Id.* ¶¶ 104-173.) The Complaint does not identify any actual bills submitted to government payers by the Retreat or any reimbursement received by the Retreat from those payers. Rather, the entirety of the Complaint is based on **inferences** drawn from the use of accounting entries and codes on particular patient accounts and his review of patient ledgers…"

In my previous submission to the TN BPR dated 08/02/15, I spoke of defense counsel's use of the inference of falsity argument to suggest that inferences formed the basis of the federal Complaint including that inferences played any role in the identity of the CMS-838's during the period at issue in the federal Complaint but the Complaint provided that information provided your willing to acknowledge it exists in the federal Complaint. However, on its face this argument would appear clever had it not been for defense counsel's admission that *"the legal standards applicable to this analysis involved a review of the facts as set forth in Relator Joseph's own complaint, with the assumption for purposes of the Motion to Dismiss that such facts are true."* Given defense counsel's admission that the legal analysis of their Motion to Dismiss ("MTD") would review the facts in the Complaint with the assumption for purposes of the MTD as true then they surely would have seen and considered the following federal Complaint content:

➔ **TN BPR:** Complaint ¶2: "Relator's claims are based on the Retreat's submission of false and fraudulent patient reimbursement claims and billing statements to the United States, including

the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration (HCFA)), and the States of Vermont, Connecticut, Massachusetts, and Nebraska to obtain payments for various mental health care services during the period from at least January 1, 2003 and continuing through the date of the filing of this Complaint.

➔ **TN BPR:** Complaint ¶13: "Relator states that all allegations in this Complaint are based on evidence obtained directly by Relator independently and through his own labor and efforts. The information and evidence he has obtained or of which he has personal knowledge, and on which these allegations of violations of the False Claims Act are based, consist of documents, computer data, conversations with authorized agents and employees of the Retreat, and his own direct observations of manipulations of computer accounting data or other actions taken by such authorized agents and employees of the Retreat..."

⏩ **QUESTION for TN BPR**: If defense counsel's legal analysis in their Motion to Dismiss ("MTD") required them to review the facts in the Complaint with the assumption for purposes of their MTD analysis that such facts are true, how can defense counsel be allowed to erroneously advance "that the entirety of the Complaint is based on inferences drawn from the use of accounting entries and codes on particular patient accounts and his review of patient ledgers" when Complaint ¶2 and ¶13 demonstrate clearly that defense counsel were advancing flat out lies that defy the spoken word of the 59 page federal Complaint?

⏩ **TN BPR**: MTD Page 7 2nd Full Paragraph **(Part 3 of 3)** Defense counsel state as follows:

"The Complaint includes allegations regarding 32 separate patient accounts, spanning roughly seven years, with respect to which it asserts that the Retreat used Code 21 to eliminate credits owed to federal and state government payers. (Id. ¶¶ 104-173.)" Defense counsel having cited virtually all of the key paragraphs of the federal Complaint including ¶'s 104-173 go further to assert falsely that *"The Complaint does not identify any actual bills submitted to government payers by the Retreat or any reimbursement received by the Retreat from those payers. Rather, the entirety of the Complaint is based on inferences drawn from the use of accounting entries and codes on particular patient accounts and his review of patient ledgers."*

Note to TN BPR: If I failed to identify any actual bills or any reimbursement received by the Retreat from those payers as defense counsel allege falsely on MTD page 7 above, how does defense counsel explain Complaint ¶127 which states as follows: "Finally, **the printed RA** appearing in the Retreat's **hardcopy records conclusively shows** that such an illegitimate juggling of overpayments is in fact what happened: it contains a handwritten annotation in Rose Dietz' handwriting showing that the recoupment of overpayments made with respect to Patients 4 through 7's claims was "paid for" by the Retreat using an overpayment amount transferred from Patient 3's ledger, stating unequivocally that the amount of $6932.84 had been "took [sic] from o/p [Patient 2]."

Moreover, if *"the entirety of the Complaint is based on inferences"* as defense counsel allege, how do they explain away Complaint ¶127? Indeed, Complaint ¶127 and many others make it abundantly clear that the suggestion that "inferences" comprised the "entirety" of the Complaint defy and mislead the tribunal when the written word of the federal Complaint makes clear defense counsel's assertions were materially misleading, false and not representative of candor before the tribunal nor resembling anything remotely promoting justice.

TN BPR: MTD Page 13 1st Full Paragraph Defense counsel state as follows:

"The Complaint discusses only three circumstances with respect to which Mr. Joseph suggests that false claims were allegedly submitted to government payers. His allegations, however, fall well short of the particularity required by Rule 9(b). In paragraph 101, the Complaint refers to the Retreat recoding charges and resubmitting claims after receiving partially paid claims from CMS. According to the Complaint, such resubmitted claims caused "Medicare or Medicaid to make duplicate for the same service." (Compl. ¶ 101 (emphasis added)).) The Complaint, however, **(1)** fails to include any specific examples or dates of such resubmission of claims, **(2)** does not allege with any certainty that any claim was submitted to a particular government payer for reimbursement, **(3)** and does not allege fraudulent intent." (Note to TN BPR: I have separated the 3 areas I will address by the insertion of the numbers **(1), (2) and (3).**

RESPONSE TO TN BPR:

Here again, anyone with two active brain cells who reads the federal Complaint in sequential order by paragraph/page would see very clearly the paragraph defense counsel stake their erroneous claims on, specifically Complaint ¶101, represent material misrepresentations of federal Complaint factual content, as they purposely leave out the intended use and context of Complaint ¶101 in the Complaint and assert material falsehoods. Let's recap Complaint ¶101 in its entirety then I will address the three areas highlighted in **Red** above that fly in the face of factual content of the federal Complaint:

➔ **TN BPR:** Complaint ¶101 states as follows: "When the Retreat receives a partially paid claim from CMS, the Retreat recodes all charges, including those for which payments have previously been resolved from CMS, and then resubmits the full claim, causing Medicare or Medicaid to make duplicate payments for the same services. This creates an overpayment credit in favor of Medicare or Medicaid."

➔ **TN BPR:** Indeed, Complaint ¶101 was one of several introductory paragraphs including Complaint ¶96-¶103 that laid the foundation for the import of the Retreat's fraudulent transactional behavior whose pattern didn't begin to be described with specific patient examples until Complaint ¶'s104-¶107 where Patient 1 was discussed; Complaint ¶108-¶115 for Patient 2; Complaint ¶116-¶128 for Patients 3-7; Complaint ¶129-¶142 for Patient 8; Complaint ¶143-¶150 for Patient 9 and continuing for all 32 patient examples.

As to defense counsel's false and material misrepresentations of factual content by their assertions that the Complaint **(1)** fails to include any specific examples or dates of such resubmission of claims, we simply have to refer to the Complaint paragraphs that directly follow and are noted above with respect to Patients 1 thru 9 and continuing for all 32 patient examples. As to defense counsel's erroneous and materially misleading assertions that the Complaint did not "include any specific examples or dates of such resubmission of claims" defies reality as Complaint ¶104 states the Retreat's nominal charge for DOS 03/21/2006 was $1,590.00 with Medicare Part A paying $560.89 (Complaint ¶105) with $952.00 that Medicare Part A had determined (from the remittance advice no less!!!) would be the deductible amount and billable to a secondary payer. However, it's important to note that Complaint ¶106 makes clear that Medicare Part A had remitted $3,891.66 for the per diem gross charges for DOS 3/21/2006 which Complaint ¶104 specified was only $1,512.90 thus representing a much greater payment (and overpayment) than what Medicare Part A should have been paid for the one day per diem gross charge(!). Despite receiving such a large amount in excess of the gross charge per diem, the Retreat not only pocketed the excess with its code 21 "allowance reversal" but then proceeded to resubmit the deductible amount of $952.00 (Complaint ¶106 and ¶107) even though Medicare Part A had paid enough to cover both the primary and secondary payers responsibility as determined by the Medicare Part A remittance advice or "RA" with their overpayment.

As to defense counsel's material misrepresentations of federal Complaint content we turn to their false and erroneous assertions contained in Item **(2)** above that the Complaint "does not allege with any certainty that any claim was submitted to a particular government payer for reimbursement" when Complaint ¶105 states very clearly, "Accordingly, the Retreat submitted a claim for payment for DOS 3/21/2006 for Patient 1 at a per diem amount equal to the allowed charges of $1,512.90 less the $952.00 deductible designated by Medicare Part A as the patient responsibility, or $560.89." Here the Complaint was speaking directly to and from the Medicare remittance advice ("RA") that the Retreat received for the claim submission identified for DOS 3/21/2006. (Again, these amounts were taken directly from the Medicare Part A remittance advice "RA" so defense counsel claims as to the "certainty" they allege holds no water, are baseless and misrepresentative of actual federal Complaint content which couldn't be any clearer.

Further, as to defense counsel's last item that the Complaint **(3)** does not allege fraudulent intent we only have to refer to Complaint ¶106 where it states, "The patient ledger reflects that when the Medicare Part A overpayment to the Retreat was posted on April 20, 2006 using posting code 10, a simultaneous entry using posting code 21 (signifying an allowance reversal) was posted in the amount of $3,253.66; eliminating the entire balance of the overpayment from the patient ledger." Despite being overpaid by Medicare Part A and pocketing the overpayment, the Retreat also had no problem accepting payment for $952.00 from Medicaid as Complaint ¶107 articulates. Further, the false and erroneous allegations that fraudulent intent was not alleged flies in the face of abundantly clear federal Complaint content that

makes clear the usage of posting code 10 (payment) in tandem with an allowance reversals or code 21 transaction is always fraudulent (Complaint ¶103). Also refer to Complaint ¶96-99, ¶102-103.

TN BPR: MTD Page 13-14 re Complaint ¶129 Defense counsel state as follows:

"Later, in paragraph 129, the Complaint alleges that "the Retreat has also presented straightforward false claims in an effort to get paid by Medicaid sums to which it was not entitled." (*Id.* ¶ 129.) The Complaint then supposedly provides an example of such a "straightforward false claim[]" – but that example turns out to be one in which nothing improper is even alleged. Rather, the Complaint asserts that there is an entry for service 11000; that the Retreat nominal charge for that service was $2,140; that there is an entry under code 10 for a payment of $806.93; and that there is a second entry "in the amount of $1,333.07, [which] was properly posted using code 20." (*Id.* ¶130 (emphasis added).)"

TN BPR: By Attorney Matthew M. Curley and co-counsel purposely referring to the incorrect Complaint paragraph to make false assertions before the Court both he and co-conspirator Attorney Elizabeth R. Wohl advance materially false information when the Complaint paragraphs clearly show that the "straightforward false claim" discussion began in Complaint ¶131 not Complaint ¶130 as defense counsel falsely assert as the "straightforward false claim" which was discussed in at least ten (10) paragraphs of the federal Complaint but beginning at Complaint ¶131 (not Complaint ¶130 that defense counsel deviously assert) but which continued for many paragraphs that included Complaint 142¶.

Instead of advancing good faith arguments of law, defense counsel purposely manipulate and cite erroneous Complaint paragraphs that directly contradict the spoken word of the federal Complaint by misrepresenting the import of Complaint ¶130 and other paragraphs of the federal Complaint and assert incorrect references to the federal Complaint all to mislead the tribunal. Defense counsel knew what they were doing (given the *"emphasis added"* notation defense counsel stated on MTD page 14). For the record, this was not the only patient example where the federal Complaint first introduced a correct and lawful patient example to be followed by an incorrect and unlawful patient example as Complaint ¶131-142 did at length. Defense counsel had the capacity of mind to correctly reference the federal Complaint to ensure they did not advance materially false misrepresentations of fact but defense counsel deliberately chose to jettison their professional obligations to mislead the Court with material misrepresentations of fact or fraud on numerous occasions.

TN BPR: MTD Page 14 defense counsel state in the following:

"In paragraph 141, it is alleges that "the Retreat submitted claims to VSH, a Medicaid-funded program, purportedly for [a] dual-eligible patient's patient responsibility amount is designated by Medicare Part A, but in the amount of $70,829.81 rather than in the amount of $21,508.00 as the patient responsibility for these DOS was determined to be by CMS." (*Id.* ¶

141.) **(1)** The Complaint does not allege when these claims were submitted, or by whom. **(2)** In addition, the Complaint acknowledges that Mr. Joseph does not know what the appropriate reimbursement rate for this service was, and therefore, he cannot plead with particularity whether the claim submitted was, in fact, false or fraudulent. **(3)** Moreover, he has provided no basis for his assertion that the claim should be considered false simply because the amount billed to VSH allegedly differed from the guidance given in a Payment/Adjustment Report prepared by CMS. **(4)** Additionally, there are no facts alleged supporting a strong inference that the claim in question were knowingly false when submitted."

NOTE TO TN BPR: The numbers in the preceding section were added to separate and distinguish the multiple misrepresentations in the one paragraph contained on Defendant's Motion to Dismiss (MTD) at Page 14 and to allow the TN BPR to follow my responses easier which follow below:

- **RESPONSE MTD Page 14 Re: No. 1**:

(1) The Complaint does not allege when these claims were submitted, or by whom.

Complaint ¶69 clearly states "Upon information and belief, the billing for Vermont State Hospital (VSH) patients is performed manually and handled by Jennifer Broussard personally. Jamie Harvey, a Retreat employee who has dual responsibilities as a Patient Account Representative and as the Retreat's Billing Coordinator, handles the uploading of the majority of billing batches to e-Premise."

Complaint ¶130 makes clear that the correct and lawful claim for Patient 8, episode 6 was for date of service (DOS) 07/22/11 which Complaint ¶130 states "for which the Retreat at that time imposed a nominal charge of $2,140.00" and was reimbursed according to the same paragraph for $806.93 on August 31, 2011 so defense counsel have no basis to falsely assert that the Complaint didn't identify when these claims were submitted.

Complaint ¶131 makes clear that for Patient 8, episode 8 that claims were submitted for dates of service (DOS) 08/29/11 through 09/25/11 and the Retreat received payment on June 2, 2012 therefore defense counsel have no basis to mislead the Court by asserting that the Complaint fails to allege when these claims were submitted or by whom when the federal Complaint couldn't be clearer.

- **RESPONSE MTD Page 14 Re: No. 2**:

(2) In addition, the Complaint acknowledges that Mr. Joseph does not know what the appropriate reimbursement rate for this service was,

Complaint ¶129 and continuing for nineteen (19) paragraphs of the federal Complaint including Complaint ¶142 relate to the same Patient 8, for the same level of care (Service Code 11000)

but for two different admissions (episode 6 and 8) that took place very close to each other in time.

➔ **TN BPR:** Complaint ¶130 states as follows: "For example, on the ledger for Patient 8, episode 6, there is a line item for service 11000, DOS 07/22/2011, for which the Retreat at that time imposed a nominal charge of $2,140.00. Associated with the line item is a pair of entries, both of which were posted on August 31, 2011. The first of these, in the amount of $806.93, was posted using code 10; the second was in the amount of $1,333.07, and was properly posted using code 20. These entries together total $2,140.00, or the full amount of the Retreat's nominal charge for service 11000 on DOS 07/22/11."

Note of Reference for TN BPR: Complaint pages 6-7 under IV. Substantive Allegations provide an explanation for the posting codes referred. Posting Code 10 represents a payment to the Retreat and Posting Code 20 represents an allowance or contractual reduction from the payer.

➔ **TN BPR:** Complaint ¶130 clearly states that the nominal (gross) charge for "this service" was $2,140.00 and the same paragraph clearly identifies that the Retreat accepted **$806.93 as payment** (posting code 10) and the difference ($2,140.00 - $806.93 = $1,333.07) or $1,333.07 represented the contractual allowance entered under code 20 which the Retreat's Cash Poster would have taken directly from the Medicare A remittance advice (RA). Indeed, the appropriate reimbursement rate defense counsel claim **"Mr. Joseph did not know" was clearly identified** as the Retreat accepted $806.93 as a payment for this service 11000 despite defense counsel's erroneous and fraudulent assertions that "Mr. Joseph does not know what the appropriate reimbursement rate for this service was."

Indeed, Complaint ¶130 concluded by stating "These entries together total $2,140.00, or the full amount of the Retreat's nominal charge for service 1100 on DOS 07/22/2011. In this instance, the Retreat would not have known the "contractual allowance" or code 20 amount had the Retreat not received the Medicare Part A "RA" which the Retreat's Cash Poster Rose Dietz would have used to apply the payment allocation on 08/31/11 as she did in the amount of $806.93 which affirmatively demonstrated the appropriate reimbursement rate for this service 11000 despite defense counsel's false assertions that I did not know or identify the appropriate reimbursement rate.

Moreover, as Complaint ¶130 clearly stated that for service 11000 (inpatient admission) the Retreat was charging $2,140.00 for Patient 8, episode 6 you can clearly understand and follow when Complaint ¶134 states as follows:

> "As with the first set of payments in the ledger for Patient 8's episode 8, the chronologically first-posted item in each set was posted using code 10 on June 2, 2011, and indicates the payer was VSH. Each of these payments was in the amount of $524.70. The other three items in each set were all posted on June 7, 2011. The first of these was posted using code

10, and signifies a payment from Medicare A in the amount of $761.02. The second was posted using code 20, and signifies a discount or contractual allowance in favor of Medicare Part A in the amount of $854.28."

NOTE TO TN BPR: As the gross charge for service 11000 was identified in Complaint ¶130 to be $2,140.00 we can see in Complaint ¶134 that Medicare A paid $761.02 with a contractual allowance of $854.28 and the remaining $524.70 was charged and paid for by VSH or Vermont State Hospital as secondary payer.

As Complaint ¶130 was intended and did show a proper and lawful payment application, you can see that for Patient 8, episode 8 (Complaint ¶134) something was amiss with the lower contractual allowance of $854.28 as compared to Patient 8, episode 6 highlighted in Complaint ¶130 where the contractual allowance (posting code 20) was $1,333.07.

The discrepancy is explained in Complaint ¶135 which states as follows:

➔ **TN BPR**: Complaint ¶135: "The final entry in each set was posted using code 61 in the amount of $524.70, which the Retreat was using in these cases to transfer the payment of $524.70 from VSH it posted on June 2, 2011, and re-designate them as the patient-responsibility amounts required by Medicare Part A rules…."

NOTE TO TN BPR: Indeed, the historic psychiatric hospital was deviating from the Medicare RA and Medicare's Secondary Payer Guidelines to fraudulently increase the patient responsibility (code 61) to move amounts it was not entitled to into the secondary payer or VSH (Medicaid of Vermont) to pocket an extra $524.70 for each DOS in question thus the discrepancy in the contractual allowance from Complaint ¶130 vs. Complaint ¶134.

RESPONSE RE: No. 3 & 4:

(3) Moreover, he has provided no basis for his assertion that the claim should be considered false simply because the amount billed to VSH allegedly differed from the guidance given in a Payment/Adjustment Report prepared by CMS.

(4) Additionally, there are no facts alleged supporting a strong inference that the claim in question were knowingly false when submitted."

I am combining my responses for Item (3) and (4) above as the same Complaint paragraphs affirmatively demonstrate that defense counsels assertions highlighted as Item (3) and (4) above are false, misleading and fraudulent assertions before the Court given the overwhelming content of the federal Complaint which demonstrates their falsity.

Contrary to defense counsel's false and erroneous assertions in Item (3) and (4) above, please refer to the following paragraphs of the federal Complaint including ¶42, 48, 49, 51, 52, 129, 132-133, 135-142 some of which will be highlighted for the TN BPR in the paragraphs to follow.

➔ **TN BPR:** Complaint ¶141 "Notwithstanding its legal obligation to submit only claims for which documentation exists, the Retreat submitted claims to VSH, a Medicaid-funded program, purportedly for this dual-eligible patient's patient responsibility amount as designated by the Medicare Part A, but in the amount of $70,829.81 rather than in the amount of $21,508.00 as the patient responsibility for these DOS was determined by CMS. This resulted in an overpayment from VSH in the amount of $49,321.89."

➔ **TN BPR:** Because the Medicare Part A remittance advice or "RA" referred to in Complaint ¶141 directed only $21,508.00 as the patient responsibility/deductible amount this was the only amount the Retreat had documentation for to lawfully submit to any secondary payer. Complaint ¶140-141 made clear these amounts were taken directly from the Medicare Part A remittance advice ("RA") that was generated by CMS. By the Retreat submitting $70,829.81 to VSH (Medicaid of VT) as secondary payer it was **admitting** it was submitting charges **for which it did not have documentation** while affirmatively demonstrating the defendant's active fraud which was in violation of Medicare's Secondary Payer Guidelines. (Refer also to Exhibit A).

➔ **TN BPR:** As to defense counsel's misrepresentations contained in Item **(4)** there are no facts alleged supporting a strong inference that the claim in question were knowingly false when submitted", Attorney Matthew M. Curley and co-conspirator Attorney Elizabeth R. Wohl completely ignore the preceding paragraphs and specifically the content of Complaint ¶129, 132, 133, 135-142 some of these paragraphs will follow where it will be made abundantly clear that the Retreat was submitting charges to a secondary payer in excess of what the actual Medicare Part A RA from CMS had directed and which they had no supporting documentation to support - - - which according to Medicare's Secondary Payer Guidelines evidences pure passive fraud. Had defense counsel considered the facts in the Complaint as true or at all, they could see that by deviating from the Medicare Part A RA and billing larger amounts than what the Medicare Part A RA had directed which was the combined patient co-insurance and deductible amount to a secondary payer, defense counsel would easily be able to discern the claim to the VSH as the secondary payer not only evidenced a "strong inference that the claim in question were knowingly false when submitted" but represented outright fraud based on the defense attorneys cursory understanding of Medicare's Secondary Payer Guidelines. Instead, defense counsel again abandoned their professional obligations to promote justice by the purposeful use of bogus and erroneous statements, misrepresentations of material facts and flat out lies to the Court as they overlooked the very information they falsely allege didn't exist. (Refer to Exhibit A)

➔ **TN BPR:** Defense counsel continue their material misrepresentations of the facts contained in the federal Complaint when they erroneously and purposely mislead the Court by suggesting the Payment/Adjustment Report was generated by CMS, which is **false** and not at all

representative of what the federal Complaint states. By this misrepresentation alone defense counsel pollute the facts contained in the federal Complaint by their attempts to correlate their misleading assertions to an authority such as CMS when the Payment/Adjustment Report was an internal report generated by the Retreat's billing system AVATAR. (Refer to Complaint ¶137 and 138)

➔ **TN BPR:** Complaint ¶42 states as follows: "With the exception of required deductibles and coinsurance payments, participating physicians and providers are required by statute to accept payments from Medicare for health care services as payment in full for those services; neither beneficiaries nor other benefit programs may be charged by a participating provider or physician for a health care service for which the participating provider or physician has already accepted a payment from Medicare, with the exception of the required deductibles and coinsurance payments mentioned above. 42 U.S.C. §§ 1395l(a)(1), 1395u(h), see also 42 C.F.R. §§ 412.404, 412.422."

➔ **TN BPR:** Complaint ¶48 states as follows: The Medicare Secondary Payer provisions require physicians and providers to submit claims by priority so that Medicare will only pay after the primary payers have satisfied their obligations. 42 U.S.C. § 1395w-4(g)(3)(A); 42 U.S.C. § 1395y(b). The purpose of the Medicare Secondary Payer provisions is to prevent Medicare from becoming the primary payer so as to reduce Medicare costs. An overpayment will result when the secondary payer provisions are not properly applied."

➔ **TN BPR:** Complaint ¶49 states as follows: The United States is statutorily prohibited from paying as the primary payer when other payers may reasonably be expected to pay a claim. Secondary payer provisions must be coordinated among federally funded and private payers. 32 C.F.R. § 199.2(b); 32 C.F.R. § 199.8; 32 C.F.R. Part 220; 38 C.F.R. § 17.277; 42 C.F.R. Part 411; subparts B through H; 42 C.F.R. §§ 422.106, 422.108.

➔ **TN BPR:** Complaint ¶51 states as follows: "….A provider or physician may not collect any amount not authorized by statute or regulation and such amounts must be refunded as appropriate. 42 C.F.R. §§ 489.40, 489.41. Under 42 U.S.C. § 1320a-7b(a)(3), intentional concealment of or intentional failure to disclose such overpayments or billing errors is a felony."

➔ **TN BPR:** Complaint ¶52 states as follows: "When CMS pays a claim for services not provided or medically necessary, or when CMS has overpaid for any of a variety of reasons, including duplicate processing of charges, incorrect application of deductibles or coinsurance, uncovered services, services provided by a practitioner not qualified for reimbursement, services for which the charge is unreasonable, or payments to physicians who have previously collected more than the deductible or coinsurance from a beneficiary, or as a result of retention of duplicate payments, a refund is due to and a debt is created in favor of CMS. 42 U.S.C. § 1395u(l)(3); 42 C.F.R. § 411.408.

➔ **TN BPR:** Complaint ¶129 states as follows: "The Retreat has also made claims to Medicaid of Vermont for the patient responsibility portion of dual-eligible Medicare beneficiaries that greatly and fraudulently exceeded the actual amounts designated by CMS as patient responsibility, and has therefore failed, contrary to law, to accept Medicare payments and the associated required deductibles and coinsurance payments as payment in full for the services for which payment was claimed. In making such claims, the Retreat has also presented straightforward false claims in an effort to get paid by Medicaid sums to which it was not entitled and which the United States and the State of Vermont would not otherwise be required to pay."

➔ **TN BPR**: Here again, defense counsel assertions on MTD page 14 in reference to Complaint ¶141 that **(4)** there are no facts alleged supporting a strong inference that the claim in question were knowingly false when submitted" has no basis as the prior paragraph which represents Complaint ¶129 of the federal Complaint not only provides a "strong inference" but also affirmative proof that the claim was "knowingly false when submitted" because the Retreat "made claims to Medicaid of Vermont for the patient responsibility portion of dual-eligible Medicare beneficiaries **that greatly and fraudulently exceeded the actual amounts designated by CMS as patient responsibility"** despite defense counsel's knowingly false assertions to the contrary that they advanced to deceive the Court.

➔ **TN BPR**: Complaint ¶137: The anomaly of a Medicaid program paying more for the same services than Medicare Part A throughout the ledger **is partially resolved by looking to the RA for the Medicare A payments** made to the Retreat for Patient 8's entire episode 8 as well as the Payment/Adjustment Report for June 7, 2012. The RA reveals that CMS imposed a downward adjustment of $148,410.17 from the Retreat's nominal charges of $219,945.96 for the 94 day per diem days that made up Patient 8's episode 8, leaving $71,535.79 that CMS believed represented the full reasonable value of the service at the per diem rate.

➔ **TN BPR**: Complaint ¶138: "The RA also shows that CMS determined that the Medicare Part A payment would be further reduced by $21,508.00 to account for the required patient responsibility portion of the remaining charges, for a net payment of $50,027.81. Turning to the Payment/Adjustment Report for June 7, 2012, the mystery of why Medicaid would pay more for a service than Medicare Part A does is fully resolved: on June 7, 2011, three postings related to this particular RA were posted to Patient 8's ledger for episode 8."

➔ **TN BPR**: Complaint ¶139: The first of these was posted using code 10 and was in the amount actually paid by Medicare for the claim, or $50,027.81. The second of these was posted using code 20, and show a discount or allowance credit in favor of Medicare Part A in the amount of $91,970.20, or a full $56,439.97 less than the amount that the RA indicated should have been written off as a discount or allowance credit in favor of Medicare Part A.

➔ **TN BPR**: Complaint ¶140: The third posting was posted using code 61, which designates the amount that is supposed to be the patient responsibility, and was in the amount of $70,829.81.

Here again the Retreat's records diverge from the RA, as the RA indicated that only the $21,508.00 was to be designated as the patient responsibility. The patient responsibility amount listed in the Retreat's records exceeds the amount CMS designated on its RA as patient responsibility by $49,321.89.

Attorney Matthew M. Curley and co-conspirator Attorney Elizabeth R. Wohl flat out lie to the Court as it is unmistakable and clear to everyone but defense counsel that their assertions as it relates to Item (4) above that "there are no facts alleged supporting a strong inference that the claim in question were knowingly false when submitted" defies reality and runs in the opposite direction of many Complaint paragraphs specifically Complaint ¶'s 140 and 141 referenced above which evidences the Retreat's knowing falsity as any divergence from a Medicare RA or increasing the patient responsibility to bill a secondary payer represents pure passive fraud. Additionally, Complaint ¶'s 42, 48-49, 51-52 speak to Medicare Secondary Payer Guidelines and how patient co-insurance and deductible amounts should be handled and billed to any secondary payers.

➔ **TN BPR**: Complaint ¶141 states as follows: "Notwithstanding its legal obligation to submit only claims **for which documentation exists**, the Retreat submitted claims to VSH, a Medicaid-funded program, purportedly for this dual-eligible patient's patient responsibility amount as designed by Medicare Part A, **but in the amount of $70,829.81 rather than in the amount of $21,508.00 as the patient responsibility for these DOS was determined to be by CMS**. This resulted in an overpayment from VSH in the amount of $49,321.89."

➔ **TN BPR**: Complaint ¶142: The Retreat's record of submission of this claim to VSH, contained in the cash reconciliation report documents for June 2, 2012. Because 100% of the reasonable value of the services paid for by Medicare Part A was determined by CMS to be $71,535.79, but the Retreat actually received a total of $120,857.62, the total overpayment the Retreat received for this one patient's eight episode alone amounts to $49,321.83…"

Despite the overwhelming clarity of the preceding Complaint paragraphs and particularly Complaint ¶141 and ¶142 where it clearly states the Retreat received far in excess of what Medicare and CMS had determined to be the value of this patient's admission and also exceeded what Medicare/CMS had directly was the patient responsibility when the Retreat deliberately billed the secondary payer VSH for amounts that grossly exceeded those demanded by CMS but for amounts for which their client had no documentation to support. Despite this stunning reality and read out of the federal Complaint, defense counsel have the audacity to assert as noted in Item **(4)** above that "there are no facts alleged supporting a strong inference that the claim in question were knowingly false when submitted".

TN BPR: MTD Page 18 re First Paragraph:

Defense counsel state, "The Complaint, however, fails to include any allegations explaining how the use of an internal accounting code would constitute a false record or statement material to any particular obligation, or how the use of such codes would constitute a false record or statement material to any particular obligation, or how the use of such a code concealed or avoided any particular obligation the Retreat presently owed to the government."

In the above highlighted text which defense counsel asserted in their MTD at page 18 provides a stunning example of how defense counsel completely discarded large sections of federal Complaint content to advance materially misleading assertions that defy the written word and specificity contained in the federal Complaint. Specifically, I draw your attention to the following paragraphs of federal Complaint content that overwhelming confirms that defense counsel's assertions highlighted above were materially misleading and fraudulent:

TN BPR: Complaint ¶96 states as follows: "When the Retreat has billed a charge in error, it has accepted an overpayment for that charge but then conceals the existence of the overpayment by entering an offsetting amount under posting code 21, or allowance reversal. When an allowance reversal is applied to negate an amount paid in error by a government health care benefit program, the Retreat retains overpayments due and payable to the United States, Vermont, Connecticut, Massachusetts, and Nebraska in violation of its obligations to refund such overpayments in a reasonably timely manner."

TN BPR: Complaint ¶97 states as follows**: "Application of allowance reversals entered using posting code 21 to an overpayment renders the Retreat's quarterly credit balance reports submitted to Medicare and Medicaid on form CMS-838 inaccurate**. The Retreat is required, as a condition of payment, to submit accurate form CMS-838 credit balance reports so that the government can be assured of obtaining a refund of amounts it has overpaid for medical services."

TN BPR: Complaint ¶98 states as follows: "When the Retreat accepts and retains duplicate or otherwise erroneous payments it receives for services covered by Medicare, Medicaid, Tricare, and other government health care benefit programs, these overpayments are initially reflected on individual patient ledgers as balances due to the various government payers. When Rose Dietz or others acting pursuant to Robert Simpson, John Blaha, Lisa Dixon and/or Jennifer Broussard's instructions enter allowance reversals into those same patient ledgers in amounts calculated to offset these overpayments, **the ledgers no longer reflect that a balance is due the government payer that made the overpayment**.

TN BPR: Complaint ¶101 states as follows: "When the Retreat receives a partially paid from CMS, the Retreat recodes and resubmits all charges, including those for which payments have previously been received from CMS, and then submits the full claim, causing Medicare or Medicaid to make duplicate payments for the same services. This creates an overpayment credit in favor of Medicare or Medicaid.

➔ **TN BPR:** Complaint ¶102 states as follows: "Such overpayments credits are routinely concealed by the Retreat by applying a posting code 21 allowance reversal in an amount calculated to offset the credit balance owed to Medicare or Medicaid due to the overpayments. **This operation results in the patient ledger erroneously showing a zero balance when in reality, a credit remains due and payable to a government health care benefit program, and thus represents knowingly fraudulent avoidance or concealment of an obligation due and payable to the government."**

➔ **TN BPR:** Complaint ¶103 states as follows: **"This operation is knowingly fraudulent because an entry posted using code 21 is only legitimately associated with an entry of an allowance or discount credit posted using code 20 which the code 21 posting reverses**, whereas in the operation described in more detail below, entries using code 21 are associated with entries posted using code 10, which is used for payments received by the Retreat and would be associated with a code 11 or code 50 posting if the Retreat had granted an overpayment credit or refunded the overpayment, respectively.

Once the TN BPR understands the import of the preceding paragraphs of the federal Complaint including ¶96, 97, 97, 98, 101, 102 and 103 that defense counsel tried hard to pretend didn't exist, defense counsel's material misrepresentations of fact to the tribunal contained in their fraud-laden Motion to Dismiss becomes very clear as federal Complaint ¶96, 97, 97, 98, 101, 102 and 103 directly contradict and evidence the numerous falsities defense counsel assert including their laughable claim that the Complaint *"fails to include any allegations explaining how the use of an internal accounting code would constitute a false record or statement material to any particular obligation"* when Complaint ¶96, 97, 97, 98, 101, 102, 103 speak directly to their erroneous and fraudulent claims before the Court. Moreover, defense counsel's blatant misrepresentations of material fact(s) before the Court with their assertion that the Complaint did not show, *"how the use of such a code concealed or avoided any particular obligation the Retreat presently owed to the government"* are answered simply by reviewing Complaint ¶102 and Complaint ¶103 where defense counsel are caught again advancing egregious lies before the Court.

The Complaint ¶'s 96-98, ¶101- 103 are critical to understand the import of all 32 patient examples. Indeed, Complaint ¶103 makes clear the tandem use of posting code 10 (payment) together with code 21 (allowance reversal) **is always fraudulent** (as it removes any overpayment from the Retreat's client ledgers and any aging report of outstanding credits). Clearly then, defense counsel would be able to discern when Complaint ¶106 states, "The patient ledger reflects that when the Medicare Part A overpayment to the Retreat was posted on April 20, 2006 using posting code 10, a simultaneous entry using posting code 21 (signifying an allowance reversal) was posted in the amount of $3,253.66; eliminating the entire balance of the overpayment from the patient ledger."

Indeed, as to their earlier claims that the Complaint failed to show *"how the use of such a code concealed or avoided any particular obligation the Retreat presently owed to the government"* defense counsel's erroneous claims are driven home and exposed once again by Complaint ¶108 which states, "The patient ledgers for Patient 2, episodes 12 and 14, along with the

(Medicare) RA (remittance advice) associated with claims made to pay for the services listed in those ledgers **provide a further example of the Retreat's fraudulent avoidance or concealment of overpayment credits due and payable to Medicare**. On the ledger for Patient 2 episode 14, there is a line item for patient's treatment designated as service code 11000 for DOS 10/07/2005 for which the Retreat imposed a nominal charge of $1,590.00." (TN BPR refer to Complaint ¶96, 97, 98, 101, 102 and 103).

Once you understand the mechanics of the import of using certain posting codes in tandem namely the payment code of 10 and the allowance reversal code of 21 (which eliminates the credit from the ledger and any aging report) you can see more clearly how the majority of all 32 patient examples did provide exactly what defense counsel claimed to be absent despite the overwhelming clarity of the federal Complaint whose content was derived from the actual remittance advice or "RA's" for each of the 32 patient examples that resulted from the clear and obvious billing to various government payers defense counsel claim weren't identified. Indeed, despite their numerous material misrepresentation of the facts by their fraudulent assertions that the Complaint fails to identify how *"an internal accounting code would constitute a false record or statement material to any particular obligation"* there is no shortage of examples to prove their misleading and false assertions before the Court. I draw the TN BPR's attention to the following Complaint paragraphs:

➔ **TN BPR:** Complaint ¶112 states as follows: "Similarly, there is an entry that was posted on October 26, 2005 using code 21 in the amount of $1,895.85 associated with service 11000, DOS 09/27/2005, which likewise exactly offsets the difference between the Retreat's nominal charge for that service and DOS. **The net result of these transactions is that the ledger for this episode erroneously and fraudulently shows a zero balance when it should reflect an overpayment due and payable to CMS in the amount of $5,009.01**. On information and belief, this set of fraudulent transactions was conducted by Rose Dietz or another Retreat employee acting pursuant to Robert Simpson, John Blaha, Lisa Dixon and/or Jennifer Broussard's instructions."

Keeping with defense counsel's erroneous and fraudulent assertions before the Court and contained on MTD page 18 that the Complaint "fails to include any allegations explaining….how the use of such a code concealed or avoided any particular obligation the Retreat presently owed to the government.", all one has to do is refer to Complaint ¶'s 96-98, ¶101-103, ¶106, ¶108 and ¶112 as a baseline before Complaint ¶153 speaks with unmistakable clarity when it states, "This very large overpayment was made by Medicare Part A, and the presence of code 21 (reversal of allowance credit) means that "the Retreat failed to report the existence of the overpayment and pocketed the cash instead."

⏩ **TN BPR**: MTD Page 18 re Second Paragraph:

Defense counsel state, "The Complaint also alleges that the Retreat submitted quarterly and annual reports that falsely stated the Retreat's obligations. But, as noted above, it fails to identify any actual report with particularity, much less any specific inaccuracy contained therein."

Here defense counsel stake their position by suggesting that I did not identify some particular CMS quarterly filing for a specific example. When all of the examples by virtue of their unique identifiers can do the same thing, why then is this an issue? Indeed, the CMS reports for every quarter for all allegations were very clearly identified by the unique identifiers of each example despite defense counsel's continuing misrepresentations which fly in the face of the information very clearly available in the federal Complaint. Let's recap two keys federal Complaint paragraphs which demonstrate that any assertion of deficiency in this way is baseless as Complaint ¶96-97 provide the foundation for the unmistakable identity of all CMS quarterly reports as each patient example would have identified them thus making defense counsel's allegations of deficiency aka "inference of falsity argument" completely without merit or good faith and further provide material misrepresentations of factual Complaint content for the TN BPR to consider as it relates to their investigation. Let's review Complaint ¶96-97 as they are central to understanding the claims of deficiency by defense counsel that should have been just a distraction but whose false misrepresentations garnered far more traction before the Court when they were really part of the collective fraud by defense counsel to mislead the Court.

➔ **TN BPR**: Complaint ¶96 states as follows: "When the Retreat has billed a charge in error, it has accepted an overpayment for that charge but then conceals the existence of the overpayment by entering an offsetting amount under posting code 21, or allowance reversal. When an allowance reversal is applied to negate an amount paid in error by a government health care benefit program, the Retreat retains overpayments due and payable to the United States, Vermont, Connecticut, Massachusetts, and Nebraska in violation of its obligations to refund such overpayments in a reasonably timely manner."

➔ **TN BPR:** Complaint ¶97 states as follows: "Application of allowance reversals entered using posting code 21 to an overpayment renders the Retreat's quarterly credit balance reports submitted to Medicare and Medicaid on form CMS-838 inaccurate. The Retreat is required, as a condition of payment, to submit accurate form CMS-838 credit balance reports so that the government can be assured of obtaining a refund of amounts it has overpaid for medical services."

⏩ **TN BPR**: MTD Page 20 re Patient 3, episode 2:

Defense counsel state, "The Complaint's allegations concerning Patient 3 begin by describing an episode for which the Retreat properly billed and accounted. (Complaint ¶116.) The paragraphs that follow, however, contain a confusing array of conclusory and unsupported allegations, which purportedly related to an episode that lasted from July 2, 2010, to November 9, 2010."

My former attorneys spoke specifically to defense counsel's misleading assertions in our Opposition to The Brattleboro Retreat's Motion to Dismiss at Page 20 by stating the following:

"For example, the Retreat attempts to make the Complaint's allegations regarding Patient 3 more uncertain and in good faith than the Complaint actually depicts. The Complaint frequently

shows that the Retreat properly recorded accounts on occasion. This demonstrates that the Retreat's manipulation at other times was purposeful, directed and knowing."

Defense counsel surreptitiously attempt to camouflage that Complaint ¶116 was intended to illustrate the earlier episode/admission by Patient 3 episode 2 which was "properly recorded" and lawful. The second admission to the hospital for Patient 3 episode 3 is the episode/admission that is discussed in Complaint ¶'s 117-128 which defense counsel claim contain a "confusing array of conclusory and unsupported allegations" but which are intended to show as my former attorneys intended was "purposeful, directed and knowing" - - - and evidence the Retreat's myriad of fraudulent transactional behavior patterns defense counsel claim the Complaint doesn't specify.

Had defense counsel not purposely referred to the incorrect Complaint ¶116, provided the full context of the paragraphs it did cite and not overlook the many paragraphs that did evidence fraudulent intent with the intended and correct patient example, defense counsel would have no good faith reason to advance their ridiculous claims before the Court that are shown to be false and misleading by the very word of the federal Complaint.

▶▶ **TN BPR**: MTD Page 20 re Patient 3, episode 3:

Defense counsel state, "Did the VDMH underpay the Retreat by $116.97? The Complaint does not say, and indeed, **makes no allegations whatsoever about what the proper per diem rate should have been**."

➔ **TN BPR**: Complaint ¶116 which referred to Patient 3 episode 2 of 2 clearly states that "the Retreat's nominal charge per diem adolescent inpatient care without schooling (service code 11100) at that time was **$2,135.00**."

➔ **TN BPR**: Complaint ¶117 which referred to Patient 3 episode **3 of 3** clear states that "The nominal charge the Retreat submitted for Patient 3 per diem "residential" adolescent room and board (11400) was **$1,075.00**."

More importantly, Complaint ¶117 demonstrates and makes clear that defense counsel's assertion that the Complaint does not say whether "Did the VDMH underpay the Retreat by $116.97? The Complaint does not say…." represents another significant material misrepresentation of the facts as Complain ¶117 does state clearly: "Accordingly, the Retreat was paid $284.13 by the State of Vermont Department of Mental Health (DMH) using Medicaid funds and posted using code 10 on July 22, 2010, while another $673.90 was posted using code 20 for a total amount of $958.03, or a shortfall of $116.97 from the full amount necessary to balance the ledger.

Note to TN BPR: By the Complaint stating that there was a shortfall of $116.97 to balance the ledger demonstrates conclusively that the payer "DMH" had short paid the amount needed to reconcile this particular charge and date of service. Indeed, when taken with defense counsel's flat out lies that the Complaint failed to provide the proper per diem amounts coupled with this glaring misrepresentation of Complaint ¶117 demonstrates conclusively that defense counsel

deviated from the actual facts or content in the federal Complaint, manufactured their own narrative and advanced material misrepresentations of the facts in clear violation of the Rules of Professional Conduct in the State of Tennessee and by doing so have demonstrated their complicity in perpetuating a fraud in a federal Court of law.

Attorney Matthew M. Curley and co-conspirator Attorney Elizabeth R. Wohl **FLAT OUT LIE TO THE COURT** as Complaint ¶'s 116 and 117 make clear the proper per diem rate for **BOTH** episodes/admissions and levels of care for Patient 3 and confirm defense counsel's material misrepresentations of fact (fraud) before the Court. They also falsely question whether the $116.97 payment was the full amount when the spoken word of Complaint ¶117 demonstrates that the payment posted on July 22, 2010 of $116.97 was not able to "balance the ledger" conclusively showing the payer or the Department of Mental Health ("DMH") had short-payed. Indeed, this is further supported when a further payment of $116.97 was noted at the beginning of Complaint ¶118 and was posted on September 21, 2010. The same paragraph also stated DMH "having previously agreed that it had not paid enough for the per diem when it made the July remittance and therefore paid an additional $116.97 to the Retreat for that DOS' per diem in September" which it "decided in December to recoup the additional amounts it had paid in September."

Indeed, there is no end it seems to the misrepresentations by defense counsel.

TN BPR: MTD Page 20 re Patient 3: Part 1 of 2

Defense counsel assert erroneously that, "The Complaint next alleges that there are three Code 10 entries totaling $80,493.35. The Complaint makes no allegations about any claims submitted in connection with these entries, **nor does the Complaint identify the payer**."

Here again, Attorney Matthew M. Curley and co-conspirator Elizabeth R. Wohl flat out lie to the Court when they assert material misrepresentations of fact (fraud) before the Court with their erroneous claims that I did not identify the payer despite the fact that Complaint ¶'s 116, 117, 118, 119, 122, 123, 124, 125, 126, and 128 (which all related to the same patient) clearly identify the payer at issue in the federal Complaint as the Department of Mental Health (DMH) or Medicaid of Vermont which are one and the same. I will highlight the Complaint paragraphs that clearly articulated who the payer was at issue in more than ten (10) Complaint paragraphs despite defense counsel's misrepresentations of federal Complaint content in their pleadings before the Court:

→ **TN BPR**: Complaint ¶116: "**Medicaid of Vermont** has determined that determined that the amount it was willing to (and did) pay for such service on a per diem basis at that time was $768.69, reflected on the ledger by an entry under posting code 10. The posting code 10 entry of payment is followed immediately by an entry (entered for the same service on the same DOS) in the amount of $1,366.31 under posting code 20, signifying an "allowance", or write-off of a discount given to the insurer pursuant to statute, regulation, or contractual provision."

➔ **TN BPR**: Complaint ¶117: "…Accordingly, the Retreat was paid $284.13 by the **State of Vermont Department of Mental Health (DMH) using Medicaid funds** and posted using code 10 on July 22, 2010, while another $673.90 was posted using code 20 for a total of $958.03, or a shortfall of $116.97 from the full amount necessary to balance the ledger."

➔ **TN BPR**: Complaint ¶118: Unsurprisingly, then, the next entry on the ledger, associated with the same service for the same DOS, lists a payment of $116.97 from **DMH** posted using code 10 on September 21, 2010."…."The code 10 and 11 entries exactly offset each other and are likely there solely for accounting purposes, while the code 50 amount indicates that **DMH**, having previously agreed that it had not paid enough for the per diem when it made the July remittance and therefore paid an additional $116.97 to the Retreat for the DOS' per diem in September, had decided in December to recoup the additional amounts it had paid in September."

➔ **TN BPR**: Complaint ¶119: "Following this entry, but still associated with the same service on the same DOS, are several entries also posted on February 5, 2011 under code 11, ostensibly signifying a recoupment by **DMH**. This is not what actually occurred for at least some of the code 11 postings."

➔ **TN BPR**: Complaint ¶122: Finally, on March 31, 2011, there is an entry posted using code 11 to the original claim for this service and DOS in the amount of $-6932.84. This amount, when deducted from the ostensibly remaining overpayment amount brings the total overpayment for that service and DOS down to $11,620.14, which when added to the second payment of $401.10 from **DMH** posted on February 15, 2011, rises to $12,021.24. When the fact that the sets of four offsetting entries in the amount of $116.97 ended an uneven number of days after this DOS on the DOS of 8/31/2010 but the other claims activity remained the same is taken into account, the ostensible overpayment credit for service code 11400 on DOS 7/2/2010 reduces to $11,904.27, which is the amount referred as a credit due **DMH** at the end of the ledger.

➔ **TN BPR**: Complaint ¶123: The problem, however, is that at least three of the code 11 entries posted on February 5, 2011 adding up to $18,668.05 (one in the amount of $10,428.25), another in the amount of $8,239.77, and a third in the amount of $0.03) and the code 11 entry posted on March 31, 2011 in the amount of $6,932.84 were not actually refunded to **DMH**. Instead, the three code 11 entries posted on February 5, 2011 appear in an "Unapplied Cash" ledger as a single entry also posted on February 5, 2011 using code 15."

➔ **TN BPR**: Complaint ¶124: "The result of this operation is that even if the $11,907.27 still reflected as a credit balance on Patient 3's episode 3 ledger were to be fully refunded to **DMH**, the Retreat has nonetheless concealed the existence of an $18,668.05 overpayment in **DMH's** favor. In addition, that amount was posted on the "Unapplied Cash" ledger as an offset to a purported self-pay payment reversal in the same amount using code 16 some two weeks earlier on January 20, 2011. The amount of $18,668.05 also appears on a Cash Reconciliation Report, listing the poster as Rose Dietz, the Retreat's cash poster and the patient ID associated with the payment as number 30444, the "patient ID" assigned to the "Unapplied Cash" ledger. This

amount exactly matches the amount listed as recouped from a set of claims that would otherwise have been paid on the **Medicaid RA** issued to the Retreat on February 21, 2011."

➔ **TN BPR**: Complaint ¶125: The cash reconciliation report records for January 20, 2011, contain a series of payments from **DMH** posted on January 20, 2011 using code 10 totaling $18,668.05, but there are no corresponding code 11 entries for those same claims to indicate that **DMH** had recouped overpayments from the claims the code 10 postings represent."

➔ **TN BPR**: Complaint ¶126: "The import of this set of transactions is that when **DMH** recouped the funds it knew it had overpaid, it unwittingly assisted the Retreat's fraudulent activity by helping it to further conceal the existence of overpayments in unrelated ledgers. Further, the code 11 entry in the amount of $6,932.84 posted on March 31, 2011 reappears as an offsetting amount in Patient 4 through 7's ledgers that was part of a claim for which **DMH** recouped overpayments it was aware of totaling $6,932.84, an amount that is not coincidentally equally matched by the amount otherwise inexplicably "reversed" using a code 11 posting from Patient 3's ledger on March 31, 2011; the fact that this amount was moved to the other patient's ledger a mere two days before the date of the RA (April 1, 2011) listing the $6,932.84 recoupment further strengthens the inference that the Retreat applied overpayments made with respect to one patient to a recoupment of overpayments made with respect to another."

➔ **TN BPR**: Complaint ¶128: "The cumulative effect of these manipulations is that the Retreat's books reflect an overpayment credit due **DMH** that is at least $25,600.86 less than the true amount of the overpayment due and payable to **DMH**, and therefore to **Medicaid**. With respect to these two particular accounting improprieties, it would appear that the Retreat, acting through cash poster Rose Dietz, has used Patient 3's account as a "slush fund," the purpose of which is to use undiscovered overpayments to eliminate the financial effect on the Retreat when **Medicaid** executes a recoupment of overpayments it is aware of."

Despite Complaint ¶'s 116, 117, 118, 119, 122, 123, 124, 125, 126, and 128 (which all related to the same patient) and clearly identify the payer at issue in the federal Complaint as the Department of Mental Health (DMH) or Medicaid of Vermont which are one and the same, h ow many times does Attorney Matthew M. Curley have to mislead the Court with falsehoods and material misrepresentations of fact contained in the federal Complaint before the TN BPR hold him accountable for his devious misconduct?

⏩ **TN BPR**: MTD Page 20 re Patient 3: Part 2 of 2 (Continued)

Defense counsel mislead the Court by their false misrepresentations that, The Complaint **makes no allegations about any claims submitted in connection with these entries**, nor does the Complaint identify the payer." Below please find specific Complaint paragraphs where the reference to actual Claims are mentioned all of which produced the transactional behavior that was discussed in numerous Complaint paragraphs despite defense counsel's false representation that claim information was missing from this Patient 3 example:

➔ **TN BPR**: Complaint ¶120: "Ten days later, on February 15, 2011, **posted under a different claim number** but associated with the same service and DOS, there is an entry posted using

code 10 in the amount of $401.10 and an entry posted using code 20 in the amount of $673.90, totaling $1,075.00, or the full nominally charged amount of the service."

➔ **TN BPR**: Complaint ¶121: "On February 16, 2011, posted under the **original claim number** but still associated with the same service and DOS, there is an entry posted using code 65 in the amount of $1,075.00, signifying that the code 10 and code 20 entries posted on February 15, 2011 **were transferred to the original claim for that service and DOS**."

➔ **TN BPR**: Complaint ¶122: "Finally, on March 31, 2011, there is an entry posted using code 11 to the original claim for the service and DOS in the amount of $-6,932.84." Also in the same paragraph, "When the fact that the sets of four offsetting entries in the amount of $116.97 ended an uneven number of days after this DOS on the DOS of 08/31/2010 but **the other claims activity** remained the same is taken into account, the ostensible overpayment credit for service code 11400 on DOS 7/02/2010 reduces to $11,904.27, which is the amount reflected as a credit due to DMH at the end of the ledger."

➔ **TN BPR**: Complaint ¶125: "The cash reconciliation report records for January 20, 2011, contain a series of payments from DMH posted on January 20, 2011 using code 10 totaling $18,668.05, but there are no corresponding code 11 entries **for those same claims to indicate that DMH** had recouped overpayments **from the claims the code 10 postings represent**. Instead, later in the report records, there is an entry posted on January 20, 2011 using code 16 and purportedly representing a reversal of a self-pay payment from the "Unapplied Cash" ledger in the amount of $18,668.05."

➔ **TN BPR**: Complaint ¶126: "…Further, the code 11 entry in the amount of $6,932.84 posted on March 31, 2011 appears as an offsetting amount in Patient 4 through 7's ledgers that **was part of a claim for which DMH recouped overpayments** it was aware of totaling $6,932.84, an amount that is not coincidentally equally matched by the amount otherwise inexplicably "reversed" using a code 11 posting from Patient 3's ledger on March 31, 2011; the fact that this amount was moved to the other patient's ledger a mere two days before the RA (April 1, 2011) listing the $6,932.84 recoupment further strengthens the inference that the Retreat applied overpayments made with respect to one patient to a recoupment of overpayments made with respect to another.

⏩ **TN BPR**: MTD Page 20 re Footnote 15: Here defense counsel assert material misrepresentations by their conclusive statement that an $80k overpayment isn't plausible. First of all, nowhere in the federal Complaint does it say it is plausible and the attached client ledger with notations written within the PDF file provide further narrative that defense counsel's Footnote is materially misleading and by the evidence noted as Exhibit C defense counsel are flat out lying to the Court. (See Exhibit C).

⏩ **TN BPR**: MTD Page 18, Footnote 12

Defense counsel state, "To the contrary, the Complaint acknowledges occasions when an allegedly inaccurate accounting code was used, but the overpayment in question was repaid in full. (*See, e.g.* Compl. ¶¶ 93, 162.)

➔ **TN BPR**: Complaint ¶93 states, "In May of 2012, Relator Thomas Joseph learned that Rose Dietz, the Retreat's cash poster, had entered allowance reversals eliminating about $7,000 overpayment credits due to Vermont Medicaid programs. The State of Vermont nonetheless recovered those overpayments because another PAR (Patient Account Representative), Lyndsay Sunderland, had printed out the particular patient ledger involved **prior to the reversal by Rose Dietz** and manually filled out and sent in the overpayment credit due. On information and belief, absent this manual request, the overpayment would have been retained by the Retreat due to the allowance reversals."

➔ **TN BPR**: In Complaint ¶93 (cited in Footnote 12) you see two different Retreat employees taking steps that were directly opposite of each other: one was lawful and correct and the other was unlawful and fraudulent. Defense counsel purposely advance only part of the narrative contained in Complaint ¶93 while advancing material misrepresentations of fact (fraud) that contradict what Complaint ¶93 actually stated which couldn't be any clearer.

➔ **TN BPR**: In Complaint ¶162 (also cited in Footnote 12) you see defense counsel assert a material misrepresentation of fact as they falsely suggest and implied the overpayment was voluntarily "repaid" which is not what the federal Complaint.

The Brattleboro Retreat did not voluntarily "repay" anyone. Complaint ¶162 makes clear that the payer in question, the Massachusetts Behavioral Health Partnership (MBHP) forcibly "took back" their overpayment via the recoupment process where MBHP not The Brattleboro Retreat deducted this large overpayment eight months later from a much larger payment MBHP was remitting to the hospital. The recoupment occurred eight months after the Retreat had deliberately wiped the large credit balance off its books and into their pockets with a reversal transaction. Defense counsel knew this because that is what Complaint ¶162 clearly articulates. Despite this, defense counsel purposely mislead the Court with their material misrepresentations of fact by suggesting the Retreat voluntarily refunded the overpayment which they did not do. As if anyone had any doubt, defense counsel purposely overlooked Complaint ¶164 which stated in part as follows:

"Instead, the Retreat entered these amounts on the patient ledger using code 21, which would and did have the effect of removing them from the ledger balance in such a way as to not result in a credit to the payer's account being entered; **MBHP only discovered and recouped these amounts due to its own efforts, and not due to any attempt by the Retreat to comply with its obligation to report and promptly repay any overpayments it becomes aware of."**

The MBHP $105,000.00 overpayment example was discussed at length in my 08/02/15 submission to the TN BPR on pages 12-14. Please refer to the earlier submission for additional analysis on this material misrepresentation of the facts by Attorney Matthew M. Curley and co-conspirator Attorney Elizabeth R. Wohl.

Defense counsel mislead the Court with deliberate and purposeful misrepresentations in their legal pleadings that advanced the false and erroneous assertion that the $105,000.00 overpayment was *voluntarily* "repaid" and by doing so deliberately ignored the facts in the federal Complaint that showed the Retreat had deliberately entered a reversal transaction eight months earlier from the time of the forced recoupment which removed the large overpayment from the client ledger and into the Retreat's pockets and operating cash. Indeed, Complaint ¶164 couldn't be any clearer as it stated "MBHP only discovered and recouped these amounts due to its own efforts, and not due to any attempt by the Retreat to comply with its obligation to report and promptly repay any overpayments it becomes aware of."

Regrettably, defense counsel's purposeful misrepresentations of clear and unambiguous federal Complaint content in this one example can be directly tied to the Order and Opinion entered on August 10, 2014 by Judge William K. Sessions as the Judge himself was influenced by the false and misleading assertions by defense counsel. Despite the Retreat pocketing this massive overpayment eight months before the Commonwealth of Massachusetts discovered their own error, defense counsel made the deliberate and purposeful decision to assert misleading responses in their pleadings despite their professional obligations to promote justice as Officers of the Court.

Indeed, in the preceding example involving the $105,000.00 that was discussed in at least ten (10) Complaint paragraphs defense counsel would have been able to discern that for the eight months the $105,000.00 overpayment had been suppressed by the entry of the fraudulent "allowance reversal" which removed the credit balance from any aging report of outstanding credit's the Retreat would generate to comply with the CMS-838 requirements up until the payer MBHP recouped this massive overpayment any CMS-838 filing subsequent to the initial allowance reversal would have been fraudulent including any filings prospective from the initial allowance reversal that removed the $105,000.00 from the client ledger. Because Medicare providers are obligated to report overpayments going back in time to when they first began participating in the Medicare program the "specificity" of this one massive example would have been compounded each and every time the Retreat submitted a CMS-838 where this amount was not included in the hospital's quarterly filing.

When considering Tenn. Sup. Ct. R. 8, RPC 1.0(d) definition of "Fraud" or "fraudulent" denotes an intentionally false or misleading statement of material fact, an intentional omission from a statement of fact of such additional information as would be necessary to make the statements made not materially misleading, and such other conduct by a person intended to deceive a person or tribunal with respect to a material issue in a proceeding or other matter.

Note to TN BPR: By defense counsel asserting that the $105,000.00 was "repaid in full" despite the overwhelming clarity of Complaint ¶164 where it states *"MBHP only discovered and recouped these amounts due to its own efforts, and not due to any attempt by the Retreat to comply with its obligation to report and promptly repay any overpayments it becomes aware of"* should without question be considered "an intentional omission from a statement of fact

of such additional information as would be necessary to make the statements made not materially misleading, and such other conduct by a person intended to deceive a person or tribunal with respect to a material issue in a proceeding or other matter as directed by Tenn. Sup. Ct. R. 8, RPC 1.0(d)."

TN BPR: MTD Page 18 (Last paragraph):

Defense counsel state, "The Complaint also alleges that the Retreat submitted quarterly and annual reports that falsely stated the Retreat's obligations. But, as noted above, it fails to identify any actual report with particularity, much less any specific inaccuracy contained therein.

The above highlighted statement above is a material misrepresentation of the facts contained in the federal Complaint which overwhelmingly identified the "inaccuracy(ies)" that defense counsel falsely assert were absent in the Complaint. Indeed, despite 32 patient examples that represented real claims or "bills" to government or other payers memorialized in the federal Complaint provided defense counsel with numerous instances of the "specific inaccuracy" they assert falsely didn't exist despite advancing material falsehoods to paint the Complaint as overly vague and deficient.

As for defense counsel's assertion that the Complaint "fails to identify any actual report with particularity, much less any specific inaccuracy contained therein" I will demonstrate that the defense counsel's assertions fly in the face of actual federal Complaint content and therefore, represent additional affirmative material misrepresentations of fact or fraud before the tribunal. I reference as follows:

➔ **TN BPR**: Complaint ¶97: **"Application of allowance reversals entered under posting code 21 to an overpayment renders the Retreat's quarterly credit balance reports submitted to Medicare and Medicaid on form CMS-838 inaccurate.** The Retreat is required, as a condition of payment, to submit accurate form CMS-838 credit balance reports so that the government can be assured of obtaining a refund of amounts it has overpaid for medical services."

NOTE TO TN BPR: Once you have a baseline understanding that every time a code 21 "allowance reversal" is used in tandem with a code 10 or payment and mentioned in the Complaint it removes any chance that the amount in question (that was reversed and removed from the client ledger) would ever appear in any aging report of credits the Retreat would be required to use to determine any outstanding credits to report on the corresponding CMS-838 quarterly reports ensuring any filing for a period where just one "allowance reversal" had occurred would ensure its inaccuracy and fraudulent submission to the government. Therefore, if you understand that the aging credit reports the Retreat would use to comply with the CMS-838 requirements for the CMS-838 quarterly reports would never capture those overpayments reversed with code 21 allowance reversals you can then understand that every time a code 21 reversal is mentioned throughout the 59 page federal Complaint it's a certainty that the corresponding CMS-838 quarterly report for the corresponding quarterly period referred in the Complaint would be affirmatively fraudulent. Therefore, when defense falsely assert that the

Complaint "fails to identify any actual report with particularity, much less any specific inaccuracy contained therein" it defies the specific accuracy identified throughout the federal Complaint where each code 21 allowance reversal and amounts mentioned in the Complaint would demonstrate "the specific inaccuracy" defense counsel claim doesn't exist while providing simultaneous certainty that the corresponding CMS-838 quarterly filing would be fraudulent and the quarterly report in question would be identified by the dates of services referred together with the dates of the code 21 allowance reversals identified in each patient example. By considering this fact as a backdrop, you then recognize that the federal Complaint **DID** reference "actual reports with particularity" and provide overwhelmingly the "specific inaccuracies" defense counsel erroneously and fraudulently claim were not found in the Complaint. Sure, one could allege that I failed to cite in the Complaint the second quarterly filing from 2003 for some unspecified allowance reversal but the stunning reality is that the federal Complaint **DID** provide the actual reports with particularity because the identity of the corresponding CMS-838 report would have been the quarterly filing that comprised the date of the code 21 allowance reversal transaction. This analysis requires a willingness to look at defense counsel's erroneous misrepresentations from a different but logical perspective which then allows you to see defense counsel's material misrepresentation of the facts before the tribunal more clearly.

➔ **TN BPR**: Complaint ¶98: "When the Retreat accepts and retains duplicate or otherwise erroneous payments it receives for services covered by Medicare, Medicaid, Tricare, and other government health care benefit programs, these overpayments are initially reflected on individual patient ledgers as balances due to the various payers. When Rose Dietz or others acting pursuant to Robert Simpson, John Blaha, Lisa Dixon and/or Jennifer Broussard's instructions **enter allowance reversals into those same patient ledgers in amounts calculated to offset these overpayments, the ledgers no longer reflect that a balance is due the government payers that made the overpayment**."

➔ **TN BPR**: Complaint ¶99: "As a result of the Retreat's practice of using posting Code 21 allowance reversals to offset overpayment credits due government payers, **any computer reports for overpayments or credit balances would not reflect the existence of overpayments on accounts manipulated in this manner.**"

➔ **TN BPR**: Complaint ¶102: "**Such overpayment credits are routinely concealed by the Retreat by applying a posting code 21 allowance reversal in an amount calculated to offset the credit balance owed to Medicare or Medicaid due to the overpayments**. This operation results in the patient ledger erroneously showing a zero balance when in reality, a credit remains due and payable to a government health care benefit program, and thus represents knowingly fraudulent avoidance or concealment of an obligation due and payable to the government."

➔ **TN BPR**: Complaint ¶103: "**This operation is knowingly fraudulent because an entry posted using Code 21 is only legitimately associated with an entry of an allowance or discount credit posted using code 20 which the code 21 posting reverses**, whereas in the operations described in more detail below, entries posted using code 21 are associated with entries posted

using code 10, which is used for payments received by the Retreat and would be associated with a code 11 or code 50 posting if the Retreat had granted an overpayment credit or refunded an overpayment, respectively.

Complaint ¶174 states "On information and belief, **each and every form CMS-838** (the quarterly balanced reports the Retreat is required to submit to CMS through the CMS carrier or fiscal intermediary) **submitted by the Retreat from 2003 to the present time has omitted, with knowledge and intent to defraud, overpayments due and payable to government health care benefit plan payers**. Indeed, the federal Complaint was very specific when it advanced "each and every form CMS-838" "from 2003 to the present time"… has omitted, with knowledge and intent to defraud, overpayments due and payable to government health care benefit plan payers." There was no need to recite each and every CMS-838 as they all were fraudulent.

Further, Complaint ¶174 expanded on the "specificity" by stating "Because the Retreat has a policy or practice of retaining overpayments from commercial insurers, self-pay patients, and government health care benefit plans, the allowance (code 20 entries) that remain falsely reflect that the Retreat gave larger discounts for services that rendered to government health care benefit plan beneficiaries than it actually did. As a result, **each and every cost report submitted to CMS from 2003 to the present time** through the Retreat's carrier and/or fiscal intermediary reflected higher unreimbursed costs of care than it actually incurred. On information and belief, these reports were prepared with knowledge of or reckless disregard for their falsity and certified, falsely, as accurate and complete by Robert Simpson, John Blaha, Lisa Dixon, and/or Jennifer Broussard. Submission of accurate and complete annual cost reports to CMS is a condition of payment of Medicare and Medicaid reimbursement."

TN BPR: MTD Page 20 re Patient 3: (1 of 2)

Defense counsel state, "That Mr. Joseph does not know what these actually signify is reflected by his speculation that "[t]he code 10 and 11 entries exactly offset each other *and are likely there solely for accounting purposes.*" (*Id*. ¶118.)

On its face, this assertion by defense counsel might have the allure of plausibility, and admittedly could have been clearer in the federal Complaint, but defense counsel can't escape that Complaint ¶113, ¶114 and ¶115 speak directly to what defense counsel incorrectly point to as a deficiency as they completely ignored Complaint ¶113-115 to materially mislead the Court by the cited phrase which was not only taken out of context but crafted with clear ignorance of their professional obligations to be mindful of the facts asserted in the federal Complaint. Advancing falsities is certainly not a way to promote justice despite the reality that the federal Complaint spoke to the very transactional behavior defense counsel have falsely tried to assert may constitute some glaring hole in my core allegations or worse, some deficiency in the legal standard required in the pleadings before the Court. Not so! If anything, it reinforces their client's guilt! Let's recap:

➔ **TN BPR**: Complaint ¶113: "The Retreat has also used other methods to fraudulently conceal the existence of overpayments credits due and payable the government health care benefit

programs. One such method is and has been utilized when a government health care benefit program discovers that it has overpaid a claim and executes a recoupment of such funds."

TN BPR: MTD Page 20 re Patient 3, episode 3

Complaint ¶114: "When this occurs, the Retreat's practice is and has been to shift undiscovered overpayments from one patient's ledger to the patient ledger(s) from which a government health care benefit program wishes to recoup the overpayments it has discovered, thereby retaining the overpayment on the first patient's claim."

Note to TN BPR: It's important to understand Complaint ¶114 was also introducing a key fraudulent practice employed by the Retreat to manipulate their accounting records using code 11 as part of its wholesale fraud. Indeed, this transactional behavior is very much tied to the entire transactional behavior in the federal Complaint and the Retreat's affirmative submission of false claims as well as fraudulent CMS-838s and annual Hospital Cost Reports for the entire period at issue.

Under Section IV. Substantive Allegations, the definition provided in the federal Complaint for code 11 on page 6 at Item "d." as follows: "Code 11" is the posting code used by the Retreat to indicate a payment by the Retreat of a credit or set-off to an insurer, including a government health benefit care plan."

Note to TN BPR: The Retreat created code 11 to be used for "recoupments" not the Retreat's "voluntary" payment or return of an overpayment, but more importantly, represents a further example of how the Retreat manipulated it's billing system AVATAR from its intended purpose for recoupments alone but expanded fraudulently code 11's use for the concealment of overpayments which they did by stashing significant sums in various "Unapplied Cash Ledgers" which were also discussed in my last submission to the TN BPR dated 09/17/15 which Complaint ¶115 directly speaks to.

Complaint ¶115: "In addition, the same method is used to simply transfer overpayments from patient ledgers to an "Unapplied Cash" record using posting code 11, normally reserved for insurer recoupments of overpayments, **effectively concealing the existence of the overpayments will not be reflected in the Retreat's form CMS-838 credit balance reports."**

TN BPR: MTD Page 21 re Patient 9:

Defense counsel state, "For example, the Complaint alleges that the first payment received by the Retreat for this episode "was posted using code 11 – which, according to the Complaint's allegations, reflects a payment by the Retreat, not a payment to the Retreat (Compare Compl. ¶18(d) with ¶131.)."

Indeed, defense counsel deliberately abbreviate a key sentence referenced in the federal Complaint that contained the definition and explanation for code 11 which was used by the Retreat to indicate "a payment by the Retreat **of a credit or set-off to an insurer, including a government health benefit care plan."**

Indeed, defense counsel are caught conveying a half sentence of federal Complaint content to mislead the Court that's how desperate they were! Another material misrepresentation of the facts only giving the Court half the sentence! I sure hope the TN BPR sees just how devious (and desperate) Attorney Matthew M. Curley and his co-conspirator Attorney Elizabeth R. Wohl really were during litigation.

TN BPR: MTD Page 22 re Patient 9:

Defense counsel's material misrepresentations of actual federal Complaint content are driven home with a level of clarity that defies defense counsel's surety with their erroneous assertions. Indeed, on MTD Page 22 re Patient 9, defense counsel state, *"In short, Mr. Joseph concedes that he does not know what the purported overpayment amount actually was and, accordingly, he has failed to adequately allege an overpayment."* Here again as before, defense counsel cherry pick and capture a very brief portion of the entire Complaint ¶148 content which defense counsel have manipulated falsely to support their flat out lies before the Court.

In actuality, the federal Complaint was demonstrating that the plaintiff did know the amount the Retreat would be reimbursed as the Complaint discussed rates broadly for those with pre-existing contracts, amounts it would receive from "ad-hoc" agreements and provided a lengthy analysis that justified that the Retreat owed more than just the calculations taken from the agreed upon rate of $1,000/day for room and board which was the essence of the "ad-hoc" agreement which was memorialized in the AVATAR follow up notes which is referenced and referred in Complaint ¶143 and Complaint ¶147.

Defense counsel further build the foundation to their House of False Cards by their opening statement on MTD page 23 stating as follows:

"The Complaint then goes on to reveal that Mr. Joseph does not know what price would be appropriate for the VA to pay for services other than room and board, noting only that "it is doubtful that the VA meant to pay 74% of the Retreat's nominal charge" and speculating that "the overpayment amount actually was and, accordingly, he has failed to adequately allege an overpayment for Patient 9, episode 2 should be adjusted upward by at least $569.77." (Compl. ¶148 (emphasis added).) In short, Mr. Joseph concedes that he does not know what the purported overpayment amount actually was and accordingly, he has failed to adequately allege an overpayment or any retention thereof."

Defense counsel flat out lie to the Court by manufacturing new facts and ignore the spoken word and facts contained in the four corners of the federal Complaint. For the record, Complaint ¶143 made clear that the Retreat had an "ad-hoc" agreement for $1,000/day for room and board not inclusive of physician charges (therefore, physician charges would be billed and were separately (Complaint ¶144). Complaint ¶144 also made clear the Retreat charged customarily a nominal charge of $1,880.00/day per diem.

Despite very clear assertions in the federal Complaint, defense counsel assert pathetic and highly misleading lies by their false and erroneous assertions that I did not know the amount of overpayment. Let's begin with a recap of what Complaint ¶145 actually said:

"The ledger, the attached cash reconciliation report document, and the follow-up notes report for this patient and episode show that the Retreat was paid, in addition to 94% of its nominal charges (with one exception for DOS 06/15/2009, which was paid at only 74%) for services beyond room and board, 94% of its nominal charge for room and board, or $767.20 more for each DOS than the Retreat had agreed to accept as payment in full for room and board exclusive of physician's charges and other miscellaneous charges."

➔ **TN BPR:** Complaint ¶147 was abundantly clear: "Even assuming that it was proper for the VA to pay between 74% and 94% of the Retreat's nominal charges for the services it rendered besides room and board, because the Retreat had agreed to charge only $1,000 per day for room and board for this particular patient, **the payment of $13,801.44 it received from the VA represents an overpayment due and payable to the VA in the amount of $5,370.40."**

➔ **TN BPR:** Complaint ¶148 was merely providing an analysis that when you compare the agreed upon "ad-hoc" rate of $1,000/per day with preexisting contracts the Retreat would be entitled to an additional upward adjusted as indicated. Therefore, in consideration of this, the federal Complaint makes clear that if you incorporate the upward adjustment the earlier **overpayment amount of $5,370.40 would grow to $5,940.17**.

➔ **TN BPR:** Complaint ¶149 also made clear the Retreat received overpayments when it received payments for physician charges by stating "In addition, the Retreat received a second payment from the VA for the same services and DOS that was posted on January 5, 2010 totaling $1,196.00. This amount represented the full amount of the nominal charges billed by the Retreat for physician's services" and went on to say, "True to form, Patient 9's episode 2 ledger reflects posting of these payments to each physician's charge in the ledger using code 10 on January 5, 2010, followed immediately by an offsetting entry posted the same day using code 21."

➔ **TN BPR:** Complaint ¶150 make clear that "The entire amount of the January 5, 2010 payment was an overpayment, as the Retreat had already paid more than it should have been for those services with the December 30, 2009 VA payment. The Payment/Adjustment report further documents that the posting and simultaneous concealment of the January 5, 2010 overpayment to the VA was performed by Rose Dietz." And defense counsel have the audacity to assert that "*he has failed to adequately allege an overpayment or any retention thereof.*"

Note to TN BPR: Wouldn't Complaint ¶147-150 which identified all overpayment amounts as well as their simultaneous concealment demonstrate "sufficient retention thereof"? Indeed, defense counsel's extensive material misrepresentations of factual federal Complaint content are driven home by their false assertions that I had failed to identify the overpayment(s) and now have been caught lying by their false assertions that the code 21 allowance reversals had somehow failed to demonstrate the "retention thereof" they falsely allege in their Motion to Dismiss. Here again, defense counsel's House of False Cards tumble under the scrutiny of the spoken word and material facts contained in the 59 page federal Complaint. Again, how many

times does Attorney Matthew M. Curley and co-counsel have to be caught advancing material misrepresentations of fact or lies before the TN BPR will hold Attorney Curley accountable for the fraud that he conceived, carried out and seeks to escape the reach of despite his misconduct?

TN BPR: MTD Page 24 continuing to Page 25 re Patient 31:

Here again, stunning material misrepresentation of the facts as Complaint ¶170 clearly stated that the nominal charge for this level of care (which signified per diem hospitalization charges for children and/or adolescents), was indeed $1,537.53 and the same paragraph made clear by the payment allocation of 02/16/2007 that the amounts posted represented full payment as the ledger entries confirm that the contractual allowance was known which would have only been derived from the actual remittance document which determines and specifies this amount. Indeed, the payment of $333.72 did represent full payment because the difference (from $1,537.53/day per diem) was exactly the code 20 amount of $1,203.81 which accounted for the full gross or nominal charge that the following Complaint ¶171 makes clear by its opening statement that "These amounts add up to the full amount of the nominal charge of $1,537.53, and thus constituted payment in full from Medicaid of Connecticut for this DOS and service code.

Defense counsel also purposely gloss over that Complaint paragraph ¶171 makes it clear that two payment amounts were posted to the same client ledger and thus by their assertion, for defense counsel to assert "The Complaint assumes that this represents an overpayment despite the fact that Complaint ¶170 made it clear that for the DOS and service code in question the Retreat had already been paid(!). In totality, defense counsel assert multiple material misrepresentations of fact with flat out lies to the Court as they state as follows:

> *"The Complaint assumes that this represents an overpayment of $333.72 but makes no allegations about what the proper reimbursement rate for this service code should have been, and therefore, fails to adequately allege an overpayment. The Complaint likewise fails to allege that any such overpayment was retained and provides no facts supporting a strong inference of scienter."*

Note to TN BPR #1: Complaint ¶170 makes clear the per diem or nominal charge the Retreat was charging for this level of care (per diem hospitalization charges for children and/or adolescents) was $1,537.53/per day and the beginning sentence of Complaint ¶171 confirms this. Despite this clarity, defense counsel assert material lies as evidenced by the preceding paragraph taken from MTD page 24/25 where they falsely state that the Complaint fails in some way "but makes no allegations about what the proper reimbursement rate for this service code should have been" when the proper reimbursement was clearly identified in both Complaint ¶170 and again in Complaint ¶171.

Note to TN BPR #2: As to defense counsel's materially misleading and false assertion that the Complaint "fails to adequately allege an overpayment" defies numerous Complaint paragraphs

including the stunningly clear and unambiguous implications of Complaint ¶96 and ¶102 which are highlighted below:

➔ **TN BPR**: Complaint ¶96 states as follows: "When the Retreat has billed a charge in error, it has accepted an overpayment for that charge but then conceals the existence of the overpayment by entering an offsetting amount under posting code 21, or allowance reversal. When an allowance reversal is applied to negate an amount paid in error by a government health care benefit program, the Retreat retains overpayments due and payable to the United States, Vermont, Connecticut, Massachusetts, and Nebraska in violation of its obligations to refund such overpayments in a reasonably timely manner."

➔ **TN BPR:** Complaint ¶102 states as follows: "Such overpayments credits are routinely concealed by the Retreat by applying a posting code 21 allowance reversal in an amount calculated to offset the credit balance owed to Medicare or Medicaid due to the overpayments. **This operation results in the patient ledger erroneously showing a zero balance when in reality, a credit remains due and payable to a government health care benefit program, and thus represents knowingly fraudulent avoidance or concealment of an obligation due and payable to the government."**

Note to TN BPR #3: By their material and false misrepresentations highlighted in Item #1 and #2 above, you can then see that when defense counsel further state, "The Complaint likewise fails to allege that any such overpayment was retained and provides no facts supporting a strong inference of scienter" provides for the third or #3 example of their multiple material misrepresentations in their legal pleadings come nowhere close to representing good faith arguments of law when defense counsel's assertions represent flat out lies to the Court, the same Court they were obligated to promote justice in as Officers of the Court! The Complaint paragraphs above make abundantly clear that the Retreat was taking deliberate steps via the use of the code 21 allowance reversal to engage in fraud and defense counsel have the audacity to falsely assert that this doesn't demonstrate specific "requisite scienter"?

⏩ **TN BPR**: MTD Page 25 Patient 32:

Defense counsel's lies continue as they state as follows:

> *"For Patient 32, the Complaint again simply alleges that the Retreat first posted entries under Code 10 and 21 that together equaled the nominal charge for one day's service, and then posted a later entry Code 10 for an additional $7,374.96. The Complaint does not say what the appropriate payment rate was, and therefore, has not alleged an overpayment or any retention thereof."*

As to defense counsel's materially false and misleading statement above, the strategy to deceive the Court is now developing a pattern as this material misrepresentation of the facts contained in the federal Complaint are very similar to the pattern that emerged with the prior example involving MTD Page 24 continuing to Page 25 re Patient 31.

Note to TN BPR #1: Complaint ¶172 makes clear the per diem or nominal charge the Retreat was charging for this level of care (per diem hospitalization charges for service code 11100 or the hospitalization for adolescents) was $1,695.00 and where Complaint ¶172 makes clear the Retreat had accepted as full payment $614.58 which represents the code 10 or payment for this DOS and followed by a code 20 or allowance entry for $1,080.42 totaled the full nominal charge the Retreat was charging for this level of care. This is confirmed by Complaint ¶173 where the beginning sentence of Complaint ¶173 states, “These add up to the full amount of the nominal charge, and thus should have constituted payment in full from Tricare to the Retreat for this DOS and service code.” Despite this clarity, defense counsel assert material lies when they asserted falsely that “The Complaint does not say what the appropriate payment rate was, and therefore, has not alleged an overpayment or retention thereof.”

Note to TN BPR #2: As to defense counsel’s materially misleading and false assertion that the Complaint “fails to adequately allege an overpayment” defies numerous Complaint paragraphs including the stunningly clear and unambiguous implications of Complaint ¶96 and ¶102 which were highlighted in the prior example which has similar characteristics to this material misrepresentation of material facts and patient example by defense counsel. In addition, it’s important to note that when Complaint ¶172 indicated the Retreat had applied a payment to date of service (DOS) 04/21/2005 for the inpatient hospitalization charges the remaining balance would have been zero for this date of service as the Complaint makes clear the payment allocation of 06/27/2005 resolved and paid for the charge in question that Complaint ¶173 confirms amounted to the “full amount of the nominal charge, and thus should have constituted payment in full from Tricare for this DOS and service code.”

This is critical for the TN BPR to understand because when the second large payment of $7,374.96 was posted the same DOS 04/21/2005 referred to above, any amounts for the service code referred (whose original gross charge was only $1,695.00) demonstrates to everyone but defense counsel there was no balance due hence the massive overpayment of $7,374.96 was received and posted….hence the need for the code 21 allowance reversal referred to in Complaint ¶173 which Complaint ¶96 and ¶102 overwhelmingly demonstrates the Retreat’s fraudulent intent and “requisite scienter” despite defense counsel’s numerous material misrepresentations and distortion of the facts contained in the federal Complaint.

I call upon, and implore, the Board of Professional Responsibility of The Supreme Court of Tennessee to summon the courage which I did in pursuing the litigation and to pursue all disciplinary measures available to hold Attorney Matthew M. Curley accountable to the fullest extent possible. Attorney Curley has demonstrated overwhelmingly that his continued practice of law endangers the public welfare and should never again have the opportunity to pollute our justice system or be allowed to be a participant in litigation where he could cause such huge financial harm to the American people as overwhelmingly evidenced in this matter

Thank you very much for your careful review of this very important matter.

Respectfully,

Thomas Joseph

Thomas Joseph