Sample Review File

Fictional healthcare billing matter

DEMO REPORT

About this sample

This document is a Tellcrest sample review file produced from a fictional healthcare billing matter. It demonstrates the structure and depth of a real Tellcrest review file without exposing any real case file.

Tellcrest takes scattered evidence (emails, notes, billing records, screenshots, and documents) and produces a source-linked review file that shows what happened, what supports the case, what could weaken it, and what an attorney should do next.

Important

- This is not legal advice.
- Attorney review is required before using any output.
- All names, organizations, files, facts, and allegations are fictional and used only to demonstrate the Tellcrest workflow.
- Tellcrest assists licensed attorneys with case review and does not replace attorney judgment.

Tellcrest Sample Review File

Attorney Review Dashboard

One-page review summary. Read this first before reading the full sample review file. The full review file follows on the pages after this dashboard.

CASE POSTURE **Investigation ready**	*STRONGEST DOCUMENT* **Email directive to billing staff**
EVIDENCE POSTURE **Developing**	*TOP WEAKNESS* **No clinical records reviewed**
MAIN ISSUE **Possible Medicare upcoding**	*TOP MISSING ITEM* **2016 compliance memo**

BEFORE FILING	Confirm defendant entity, damages, relator identity, and public-disclosure risk.
ATTORNEY ACTION	Review, challenge, and approve before any of this is used for a legal purpose.

320	**6**	**2**	**13**	**10**
facts extracted	people identified	conflicts found	evidence gaps	source files

Sample evidence is fictional. All organization names, file names, people, and facts in this report are used only to demonstrate the Tellcrest workflow. Nothing in this document is legal advice.

Reader's note

How to read this report

This report is not a filing draft. It is a review file. It organizes the available evidence, separates direct support from weak points, identifies missing records, and lists next steps for attorney review.

What the sections do

1. What this case is about. Plain-language summary of the alleged conduct and the leading recommendation.

2. Strongest evidence. The five most load-bearing items, each tagged to its source file.

3. Key documents. Document-by-document breakdown with bullet points on what each one shows.

4. Key people. Named individuals, their roles, and why each one matters.

5. What could weaken the case. Risks, each tagged with priority and source status.

6. What the defense will argue. The strongest counter-reads, plus what weakens each.

7. What is still missing. Documents and searches the case file does not yet contain.

8. What needs to be resolved. Conflicts inside the existing evidence.

9. How ready this is. Filing-readiness posture across eight dimensions, plus blockers.

10. What to do next. Immediate actions, pre-complaint work, and items to request from the client.

11. Non-obvious findings. Things Tellcrest noticed by reading the files together, not one at a time.

Evidence labels

Each risk in this report carries two labels.

Priority	**How likely this risk is to affect the case if left unaddressed.**
Source status	**Where the claim came from. Possible values: Direct document, Relator note, Inference from records, Missing document, Needs attorney review.**

Every claim in this report is derived from the evidence files. Where the evidence is incomplete, the report says so. Attorney review is required before any of this can be used for a legal purpose.

Tellcrest Sample Review File

Northstar Regional Health Medicare Billing Review

Generated from 320 facts across 10 sample files. 320 facts extracted · 6 people identified · 2 conflicts found · 13 evidence gaps

Allegations under review: billing for more expensive services than provided · inflating diagnosis codes to increase payment · failure to return overpayments.

Investigation ready · Evidence posture: developing

Demo notice. Sample evidence is fictional. All organization names, files, people, and facts are used only to demonstrate the Tellcrest workflow. This is not legal advice. Attorney review is required before using any output.

1. What this case is about

A billing manager at Northstar Regional Health reports that Medical Director Dr. Robert Chen directed staff to bill all patient visits at CPT 99215, the highest office-visit code, regardless of actual visit duration or complexity. Billing records show dozens of visits lasting 10 to 15 minutes billed at 99215. An internal compliance memo from 2016 reportedly flagged the same pattern and recommended corrective action, but the rate reportedly increased rather than decreased. Chen's own email confirms the directive was financially motivated and was issued over a documented written objection from the relator.

Top recommendation

Obtain the 2016 internal compliance memo and the clinical records for a sample of the billed visits before making any filing decision. Those two items are likely important to evaluating scienter (evidence the defendant knew or should have known the billing was wrong), damages, and filing readiness.

2. Strongest evidence

1. Dr. Robert Chen, Medical Director, directed billing staff to code all visits at CPT 99215 for a financial reason. When the relator objected in writing about 10 to 12 minute visits, Chen replied: *“All of them. Don’t escalate this again.”*

SOURCE · `chen_email_to_billing_staff.txt` · Nov 9 2017

> *“All of them. Don’t escalate this again.”*

2. Chen’s original email to billing staff states the 99215 directive was driven by revenue performance, not clinical accuracy.

SOURCE · `chen_email_to_billing_staff.txt` · Nov 9 2017

> *I need everyone coding at 215. Our numbers are down and we need to get them back up before end of quarter.*

3. The billing export shows a dense pattern of CPT 99215 claims at $210 each for visits recorded at 10 to 15 minutes, under NPI 1477309845, at Bayview Medical Center, across October and November 2017. The relator’s handwritten notes estimate the 99215 rate at approximately 85% of claims, against a reported national average of 25% for internal medicine.

SOURCE · `billing_export_q4_2017.csv · rows 1-50`

> *10/02/2017, NS-449821, 1477309845, 99215, Z00.00, 210.00, 12, Bayview Medical Center*

4. Compliance Director Tom Reardon reportedly told the relator that the compliance department had already flagged this coding pattern in a prior audit in 2016, and nothing was done. The relator notes the rate went up, not down, after that audit.

SOURCE · `handwritten_notes_scan.txt · p. 1`

> *He said the compliance dept had already "flagged this issue" in a prior audit. PRIOR AUDIT. So they KNEW. In 2016 they knew.*

5. Dr. Amanda Park, an internal medicine physician at Northstar Regional Health, separately reported in March 2017 that she was receiving guidance to add diagnoses to patient charts beyond what she actually assessed or treated during the visit, and that she raised this with her supervisor without resolution.

SOURCE · `forwarded_complaint_email.txt · p. 1`

> *Over the past several months I've been receiving guidance from department administration to include additional diagnoses in patient charts beyond what I have actually assessed or treated during the visit.*

3. Key documents

1. chen_email_to_billing_staff.txt

This is the single most important document in the file. It contains a named senior official's written directive to upcode, his stated financial motive, the relator's written objection, and his dismissal of that objection. It may support scienter if authenticated and connected to the correct submitting entity. Counsel should assess admissibility before relying on it.

- Chen directed all visits to be coded at 99215, citing revenue performance as the reason.
- The relator objected in writing, specifically flagging 10 to 12 minute visits and the lack of supporting documentation.
- Chen responded "All of them. Don't escalate this again," overriding the objection.
- Sally Martinez forwarded the email to Lisa Park with the note "Keep this between us for now," which is a potential admissibility and privilege risk.
- The email was copied to billing-staff@northstar-health.example, Denise Hobart, and Marcus Webb, broadening the scope of who received the directive.

2. billing_export_q4_2017.csv

This is the claim-level data that makes the pattern concrete and quantifiable. It shows specific patient IDs, dates, visit durations, and CPT codes. It is the foundation for any damages calculation and for the statistical analysis that will be needed to satisfy Rule 9(b)'s particularity requirement.

- Dozens of visits billed at CPT 99215 with recorded durations of 10 to 15 minutes, all under NPI 1477309845 at Bayview Medical Center.
- A small number of visits were billed at 99213 or 99214, showing that lower codes were available and used occasionally, which undercuts any argument that 99215 was the only code in use.
- The data covers October and November 2017, consistent with the period of Chen's directive.

3. handwritten_notes_scan.txt

These notes are the relator's contemporaneous record of what she observed, calculated, and reported internally. They contain the statistical comparison, the damages estimate, the compliance department conversation, and the relator's state of mind. They are important for corroboration but carry admissibility risk as a hearsay document with redacted content.

- Relator estimated the 99215 rate at approximately 85%, compared to a reported national average of 25% for internal medicine.
- Relator calculated a rough damages estimate of approximately $161,000 per year for Medicare alone, based on 60% overcoding at $112 per claim for 200 claims per month.
- Relator documented her conversation with compliance director Tom Reardon, including his statement that the issue had been flagged in a prior 2016 audit.
- Relator noted that Sally Martinez continued to issue updated coding guidance directing 99215 for all visits even after the compliance report.

4. Key people

Dr. Robert Chen · Medical Director, Internal Medicine, Northstar Regional Health

Issued the written directive to code all visits at 99215 for financial reasons, overrode the relator's written objection, and is the primary named actor for liability purposes.

Sally Martinez · Billing and Coding Manager, Northstar Regional Health; likely the relator

Received and forwarded Chen's directive, raised a written objection, reported to compliance, and kept contemporaneous notes. She is the likely relator and her credibility and employment status are central to the case.

Tom Reardon · Compliance Director, Northstar Regional Health (name uncertain per notes)

Received the relator's internal complaint, reportedly acknowledged a prior 2016 audit flagging the same issue, and took no documented corrective action. His knowledge and inaction are central to the knowing-violation theory.

Dr. Amanda Park · Internal Medicine Physician, Northstar Regional Health

Made an independent internal complaint in March 2017 about being directed to add diagnoses beyond what she treated, raising a separate diagnosis-inflation theory. She has retained copies of relevant communications and is willing to speak to an attorney but does not want to be a named plaintiff.

Dr. Keith Holloway · Chief of Staff, Bayview Medical Center

Received Dr. Park's informal complaint in March 2017, said he would look into it, and later told Park it was not a systemic issue. His response, or lack thereof, is relevant to the institutional knowledge and inaction theory.

Lisa Park · Billing staff member, Northstar Regional Health

Received the forwarded Chen email from Sally Martinez with the instruction to keep it between them. She is a potential witness and her knowledge of the directive is relevant. Her name appears in both the email chain and the handwritten notes.

5. What could weaken the case

Each risk carries two labels. Priority is how much it could affect the case if left unaddressed. Source status is where the underlying observation came from.

Public-disclosure bar

PRIORITY **High**	*SOURCE STATUS* **Inference from records**

The 2016 compliance audit and the coding pattern may have been disclosed in a prior government audit, CMS data release, or news report, which could strip the relator of standing to bring an FCA qui tam action.

WHY IT MATTERS

Public-disclosure risk, meaning similar allegations may already be public, can be a threshold issue. Counsel should assess whether the original-source exception applies and whether prior CMS or OIG audits of Northstar Regional Health, or public CMS utilization data for NPI 1477309845 already showing the 99215 outlier rate, would trigger this risk.

EVIDENCE EXCERPT

> *“national avg for IM practices = 25% (I looked this up on CMS website)”*

NEXT STEP

Search the OIG exclusion database, CMS Medicare Provider Utilization and Payment Data for NPI 1477309845, and PACER for any prior FCA suits against Northstar Regional Health before taking any further steps.

Relator identity and first-to-file risk

PRIORITY **High**	*SOURCE STATUS* **Relator note**

The evidence suggests at least two potential relators, Sally Martinez and Dr. Amanda Park, and possibly a third author of the handwritten notes. If any of them has already filed or consulted another attorney, the first-to-file rule under 31 U.S.C. 3730(b)(5) could bar a subsequent suit.

WHY IT MATTERS

First-to-file principles, meaning only the first filed qui tam suit on the same underlying facts can proceed, may apply here. The handwritten notes author is not clearly identified, and the tip summary refers to “I” without confirming the author is Sally Martinez. Counsel should confirm relator identity before any government disclosure.

EVIDENCE EXCERPT

> *“She’s willing to talk to an attorney but doesn’t want to be the named plaintiff.”*

NEXT STEP

Confirm the identity of the relator in the first client meeting, ask directly whether any other person has filed or consulted an attorney about these facts, and search PACER for sealed FCA complaints against Northstar Regional Health.

Admissibility of the forwarded email

PRIORITY **Medium**	SOURCE STATUS **Direct document**

Sally Martinez forwarded Chen's directive to Lisa Park with the note "Keep this between us for now," which could be characterized as an instruction to conceal the document. This may raise questions about how the document was obtained and whether it was improperly shared, affecting admissibility and the relator's credibility.

WHY IT MATTERS

Defense counsel will argue the relator improperly retained or shared confidential internal communications. While employees generally have the right to retain documents evidencing wrongdoing for whistleblower purposes, the "keep this between us" instruction could be used to attack the relator's credibility or to argue the document was obtained in bad faith.

EVIDENCE EXCERPT

> *"FYI. Keep this between us for now. - S"*

NEXT STEP

Counsel should assess whether the relator's retention of this email falls within the whistleblower document-retention safe harbor and prepare to address the "keep this between us" note in any deposition or motion practice.

Statute of limitations

PRIORITY **Medium**	*SOURCE STATUS* **Relator note**

The compliance department flagged the coding pattern in 2016, and Dr. Park's complaint is dated March 2017. If the government knew or should have known of the fraud by 2016 or early 2017, the FCA's 6-year limitations period from the date of the false claim, or 3-year period from when the government knew or should have known, may affect the recoverable damages period.

WHY IT MATTERS

Counsel should map the recoverable damages window against the applicable limitations period. The analysis can depend on when the government knew or should have known of the underlying conduct. If the 2016 compliance memo was shared with any government agency, claims from that period may be time-barred.

EVIDENCE EXCERPT

> *"He said the compliance dept had already "flagged this issue" in a prior audit. PRIOR AUDIT. So they KNEW. In 2016 they knew."*

NEXT STEP

Obtain the 2016 compliance memo to determine whether it was shared with CMS, OIG, or any government agency, and map the billing export dates against the applicable limitations period before calculating damages.

Damages proof gap

PRIORITY **Medium**	*SOURCE STATUS* **Missing document**

The relator's damages estimate in the handwritten notes is a rough back-of-envelope calculation based on assumed percentages and volumes, not actual Medicare payment data. Without CMS remittance records, the actual amount paid by Medicare versus other payers is unknown, and the damages figure cannot be verified.

WHY IT MATTERS

Damages calculations turn on the actual government overpayment, not on total billing. If a significant portion of the 99215 claims were billed to commercial insurers rather than Medicare or Medicaid, the government's actual loss is lower. Counsel should obtain payment data before quoting a damages figure.

EVIDENCE EXCERPT

> *"if 60% of visits are overcoded by ~$112 (215 vs 214 difference) and we do ~200 claims/mo... 200 x 60% = 120 claims x $112 = $13,440/month x 12 months = $161,000/year JUST MEDICARE just one provider group"*

NEXT STEP

Request Medicare 835 remittance files from CMS for NPI 1477309845 for dates of service January 2016 through December 2017 to determine actual Medicare payments on the 99215 claims.

Defendant entity ambiguity

PRIORITY **Medium** | *SOURCE STATUS* **Needs attorney review**

The billing records reference NPI 1477309845 and “Bayview Medical Center,” but the legal entity that submitted claims to Medicare, signed the Medicare participation agreement, and is the proper FCA defendant has not been confirmed. Northstar Regional Health operates through multiple affiliated legal entities.

WHY IT MATTERS

Counsel should confirm the correct legal entity before filing. The NPI holder may be a medical group rather than the hospital, which affects which entity certified compliance with Medicare billing requirements. Naming the wrong entity could lead to dismissal or amendment.

EVIDENCE EXCERPT

> *“10/02/2017, NS-449821, 1477309845, 99215, Z00.00, 210.00, 12, Bayview Medical Center”*

NEXT STEP

Look up NPI 1477309845 in the CMS NPPES registry to identify the legal entity name and address, then confirm which entity signed the Medicare participation agreement for Bayview Medical Center.

Hearsay and authentication risk for handwritten notes

PRIORITY **Medium** | *SOURCE STATUS* **Inference from records**

The handwritten notes are a scan of an undated, partially redacted document with no clear author identification. They contain second-hand statements attributed to Sally Martinez and Tom Reardon, and the author’s identity is not confirmed in the document itself.

WHY IT MATTERS

The notes are valuable for investigation but may face authentication and hearsay challenges at trial. Statements attributed to Chen via Martinez (“Chen wants it that way”) are double hearsay. The redacted portions may contain material information. The notes are most useful as a roadmap for obtaining admissible evidence, not as standalone proof.

EVIDENCE EXCERPT

> *“asked Sally about it after the staff meeting. she said “Chen wants it that way.” Just like that. Very matter of fact.”*

NEXT STEP

Have the relator authenticate the notes in a signed declaration, identify the redacted content, and obtain direct admissible evidence for each factual claim in the notes before relying on them in any filing.

6. What the defense will argue

Each defense argument is broken into the claim, why the other side will argue it, what weakens it from the existing evidence, and what counter-evidence the case still needs.

DEFENSE ARGUMENT #1

The 99215 coding was clinically justified.

Chen's email can be read as directing accurate coding of complex visits that were being undercoded, not as directing upcoding of simple visits.

WHY THEY WILL ARGUE THIS

Chen's email contains language about coding "at the appropriate level" and "more accurate" reflection of complexity, which defense will use to argue the directive was a legitimate clinical correction, not a fraud scheme.

WHAT WEAKENS IT

• Chen's same email states the directive was driven by revenue performance: "Our numbers are down and we need to get them back up before end of quarter," which is a financial motive, not a clinical one.

SOURCE · `chen_email_to_billing_staff.txt`

• When the relator specifically flagged 10 to 12 minute visits and the lack of supporting documentation, Chen did not engage with the clinical question. He simply said "All of them. Don't escalate this again."

SOURCE · `chen_email_to_billing_staff.txt`

WHAT YOU NEED TO COUNTER IT

Obtain clinical records for a sample of the billed visits to show that the documentation does not support high complexity medical decision making or 40-plus minutes of total time, which are the requirements for 99215 per the relator's notes.

DEFENSE ARGUMENT #2

The visit duration data in the billing export does not accurately reflect total encounter time.

Physicians may have spent additional time on documentation, care coordination, or review of records not captured in the face-to-face time field.

WHY THEY WILL ARGUE THIS

CPT 99215 can be supported by total time, not just face-to-face time, and defense will argue the billing export’s duration field reflects only one component of the encounter.

WHAT WEAKENS IT

- The relator states she has seen the appointment schedules and that “mostly these visits are 10–15 min,” suggesting the scheduled slots themselves were short, not just the face-to-face time.

  SOURCE · `handwritten_notes_scan.txt`

WHAT YOU NEED TO COUNTER IT

Obtain the appointment scheduling records for NPI 1477309845 for October through November 2017 to show that the scheduled slot lengths were 10 to 15 minutes, and obtain clinical notes to confirm that no additional time was documented for care coordination or record review.

DEFENSE ARGUMENT #3

The compliance department reviewed the coding pattern and determined it was not a systemic issue.

Which shows good faith and negates the knowing-violation element of the FCA.

WHY THEY WILL ARGUE THIS

Chief of Staff Holloway told Dr. Park the issue was “not a systemic issue” after reviewing her complaint, and the compliance department’s review, even if it resulted in no action, could be characterized as a good-faith internal process.

WHAT WEAKENS IT

- The compliance director reportedly told the relator that the compliance department had already flagged the same issue in a 2016 audit, and the rate went up rather than down after that audit, suggesting the internal review was not a good-faith corrective process.

  SOURCE · `handwritten_notes_scan.txt`

- After the compliance review, Sally Martinez sent updated coding guidance to the whole team still directing 99215 for everything, showing no corrective action was taken.

  SOURCE · `handwritten_notes_scan.txt`

WHAT YOU NEED TO COUNTER IT

Obtain the 2016 compliance memo and any written response from leadership to confirm that the institution was on notice and took no corrective action, and obtain Tom Reardon’s communications with Chen and senior leadership after the relator’s complaint.

DEFENSE ARGUMENT #4

The billing export covers only a short period and a limited number of claims.

And the relator's statistical comparison to a national average is not a valid benchmark for this specific patient population.

WHY THEY WILL ARGUE THIS

Defense will argue that Northstar Regional Health serves a complex patient population, that the national average for internal medicine is not the right comparator, and that the Q4 2017 data is too narrow to support a systemic fraud theory.

WHAT WEAKENS IT

• The billing export shows that even within the same dataset, a small number of visits were coded at 99213 and 99214, showing that lower codes were available and used, which undercuts any argument that the patient population uniformly required 99215.

SOURCE · `billing_export_q4_2017.csv`

• Chen's own email confirms he was aware that providers were submitting 99213 and 99214 codes and directed them to switch to 99215, which shows the shift was directive-driven, not population-driven.

SOURCE · `chen_email_to_billing_staff.txt`

WHAT YOU NEED TO COUNTER IT

Request CMS Medicare Provider Utilization and Payment Data for NPI 1477309845 for 2015, 2016, and 2017 to show the year-over-year shift in 99215 utilization rate, and obtain a coding expert to opine on the appropriate benchmark for this patient population.

7. What is still missing

Documents, searches, and records the case file does not yet contain. Items are grouped by when they are likely to matter.

Get now

Top-priority items to obtain before any further investment in the case.

ITEM	WHY IT MATTERS	LIKELY HELD BY
2016 internal compliance memorandum	If it exists, this is the single most important piece of evidence for the knowing-violation element. It would show the institution was on notice before the Q4 2017 billing period.	Northstar Regional Health compliance department; Tom Reardon likely has a copy.
CMS NPPES registry entry for NPI 1477309845	Confirms the legal entity name of the defendant before any filing or government disclosure.	Publicly available at nppes.cms.hhs.gov.
PACER search for sealed FCA complaints against Northstar Regional Health	Confirms whether a first-to-file bar exists before any further investment in the case.	PACER; publicly searchable.

Before filing

Materials that should be in hand or substantially in process before a complaint is drafted.

ITEM	WHY IT MATTERS	LIKELY HELD BY
Electronic medical records for a sample of 99215-billed visits from the Q4 2017 billing export	Counsel should plan for Rule 9(b) particularity, meaning the complaint needs specific false claims, not just a general pattern. That typically requires showing the clinical documentation did not support 99215 for those specific visits.	Northstar Regional Health; obtainable via subpoena or CID after filing, but a sample should be reviewed before filing if the relator has access.
Relator's written objection email to Dr. Chen referenced in the tip summary	The tip summary says the relator objected in writing before receiving Chen's "All of them" reply. That prior email, if it exists separately from the chain in evidence, strengthens the relator's credibility and the scienter narrative.	The relator; should be in her possession.
Medicare participation agreement and compliance certifications for the NPI 1477309845 entity	Counsel should obtain the relevant Medicare participation agreement. Certifications of compliance with Medicare billing rules are often the legal hook that makes an upcoded claim actionable.	CMS; obtainable via FOIA or CID.

Dr. Amanda Park's retained communications about the diagnosis-inflation directive	Park said she kept copies of relevant communications. These may corroborate the broader pattern and support the secondary diagnosis-inflation theory.	Dr. Amanda Park; she is willing to speak to an attorney.

For damages

Payment-level data the case cannot be filed without.

ITEM	*WHY IT MATTERS*	*LIKELY HELD BY*
Medicare 835 remittance advice files for NPI 1477309845, January 2016 through December 2017	These files show exactly which 99215 claims were paid by Medicare, the amounts paid, and any adjustments. Without them, the damages figure is an estimate.	CMS or the Medicare Administrative Contractor for the region; obtainable via CID after filing.
Medicare 837 professional claim files for NPI 1477309845, January 2016 through September 2017	Extends the damages period back to the 2016 audit finding and shows whether the pattern predates the Q4 2017 billing export.	CMS or the Medicare Administrative Contractor; obtainable via CID after filing.
Reimbursement summary 2016–2017 referenced in the document list	This document is listed in the file but its contents are not in the evidence atoms. It may contain total Medicare payment figures that would anchor the damages calculation.	The relator, based on the document list.

To counter the defense

Records that directly address the strongest defense arguments.

ITEM	*WHY IT MATTERS*	*LIKELY HELD BY*
Appointment scheduling records for NPI 1477309845, October through November 2017	Defeats the defense argument that total encounter time exceeded the face-to-face duration recorded in the billing export. If scheduled slots were 10 to 15 minutes, total time could not have reached the 40-minute threshold for 99215.	Northstar Regional Health scheduling system; obtainable via subpoena or CID.
Tom Reardon's written communications with Chen and senior leadership after the relator's complaint	Defeats the good-faith compliance defense by showing what the institution actually did, or did not do, after being put on notice by the relator.	Northstar Regional Health compliance department; obtainable via CID.

CMS Medicare Provider Utilization and Payment Data for NPI 1477309845, 2015 through 2017	Provides a government-sourced year-over-year utilization rate for 99215 that defeats the defense argument that the Q4 2017 data is too narrow and that the patient population justifies a high 99215 rate.	Publicly available via CMS data portal.

8. What needs to be resolved

Chen's email contains two conflicting framings of the coding directive.

One framing is a financial-performance fix, another is a clinical-accuracy correction.

Why this matters. The financial framing supports scienter; the clinical framing is the defense's primary argument. Both appear in the same document. The jury will have to choose which framing reflects Chen's actual intent, and the answer affects liability.

Evidence A	*Evidence B*
Chen stated the directive was financially motivated: "Our numbers are down and we need to get them back up before end of quarter." *SOURCE* · `chen_email_to_billing_staff.txt`	Chen also wrote: "Going forward I want to make sure we're coding at the appropriate level for each encounter. We have room to be more accurate in how we reflect the complexity of these visits." *SOURCE* · `chen_email_to_billing_staff.txt`

To resolve. Obtain clinical records for the billed visits to show whether the documentation actually supports 99215, which will indicate whether the "accuracy" framing in the email matches what the records show.

The compliance director and the chief of staff describe the 2016–2017 internal review differently.

Reardon said the compliance department had flagged the issue in 2016. Holloway told Dr. Park in March 2017 that the issue was "not a systemic issue."

Why this matters. If the compliance department flagged a systemic issue in 2016 and Holloway simultaneously concluded it was not systemic in 2017, one of those conclusions is wrong. This affects whether the institution had actual knowledge of a systemic problem and chose to ignore it, which is central to the knowing-violation theory.

Evidence A	*Evidence B*
Compliance director Reardon reportedly told the relator the compliance department had already flagged the coding issue in a prior 2016 audit. *SOURCE* · `handwritten_notes_scan.txt`	Holloway told Dr. Park he looked into her March 2017 complaint and it "wasn't a systemic issue." *SOURCE* · `forwarded_complaint_email.txt`

To resolve. Obtain the 2016 compliance memo and Holloway's written notes or communications from his March 2017 review to determine what each person actually knew and what they concluded.

9. How ready this is

Overall status: **Investigation ready** · Evidence posture: **developing**

DIMENSION	*STATUS*	*WHY THIS STATUS*	*WHAT IS MISSING*
Liability	**Partial**	The Chen email and billing export support a plausible upcoding theory.	Clinical records needed to show the specific claims were false.
Claim specificity	**Partial**	The billing export provides claim-level data with patient IDs, dates, and codes.	Government payer status of each claim has not been confirmed.
Damages	**Weak**	Only a rough estimate in the relator's handwritten notes is in the file.	Actual Medicare payment data.
Relator clarity	**Partial**	The likely relator is Sally Martinez.	Handwritten notes author confirmation; first-to-file assessment for Dr. Park.
Defendant clarity	**Weak**	Northstar Regional Health operates through multiple affiliated entities.	Confirmed legal entity behind NPI 1477309845.
Evidence provenance	**Partial**	Chen email and billing export appear to be authentic business records.	Verification of handwritten notes; 2016 compliance memo review.
Admissibility	**Weak**	"Keep this between us" note and hearsay in handwritten notes both raise concerns.	Admissibility plan for each item before filing.
Defense exposure	**Weak**	Dual framing in Chen's email gives the defense a clinical-accuracy argument.	Clinical records showing the documentation did not support 99215.

Blockers

- The legal entity that submitted claims to Medicare under NPI 1477309845 has not been confirmed, making it impossible to name the correct defendant.
- No clinical records have been reviewed to confirm that the billed visits did not support 99215, which is required to allege the specific claims were false.
- Actual Medicare payment data has not been obtained, so the damages figure cannot be stated with any reliability.
- The public-disclosure bar and first-to-file risk have not been assessed, and either could end the case before it starts.

10. What to do next

Three checklists for case-team handoff. Each item should be completed and re-reviewed by counsel before any of this work product is used.

STEP GROUP

Immediate

Before any further investment in the case

- **Search the CMS NPPES registry for NPI 1477309845**
  Confirms the correct defendant entity before any further investment.
- **Search PACER for sealed FCA complaints against Northstar Regional Health**
  Rules out a first-to-file bar before any disclosure.
- **Conduct an intake interview to confirm relator identity and first-to-file risk**
  Confirm the handwritten-notes author and ask about prior counsel.
- **Search OIG and CMS audit sources for prior public disclosure**
  Assesses the public-disclosure-bar risk before any government filing.

STEP GROUP

Before complaint

Before drafting or filing a complaint

- **Request the 2016 internal compliance memorandum**
  Single most load-bearing item for the knowing-violation theory.
- **Have a coding expert review a sample of Q4 2017 patient records**
  Required for Rule 9(b) particularity. At least 20 records.
- **Contact Dr. Amanda Park through counsel**
  Obtain her retained communications; assess corroborating-witness role.
- **Obtain CMS Medicare Provider Utilization and Payment Data for NPI 1477309845**
  Establishes the year-over-year shift in 99215 utilization rate.

STEP GROUP

Ask the client for

Items the relator is best positioned to provide

- **Complete Chen email thread**
  Including any replies from Denise Hobart, Marcus Webb, or other billing staff.
- **Written objection email**
  The relator's written objection to Chen before his "All of them" reply.
- **reimbursement_summary_2016_2017.txt**
  Listed in the document inventory but no atoms appear in evidence yet.
- **quarterly_audit_excerpt_2017.txt**
  Listed in the document inventory but no atoms appear in evidence yet.

11. Non-obvious findings

Things Tellcrest noticed by reading the files together, not one at a time. These are the cross-file observations a busy reader could miss on a single pass.

FINDING #1

The strongest document also contains the defense's best argument.

WHY IT MATTERS

Chen's email includes financial-pressure language, but also clinical-accuracy language. The same document helps both sides.

SOURCES

SOURCE · `chen_email_to_billing_staff.txt`

ATTORNEY NEXT STEP

Compare the email against clinical records to see whether the clinical explanation is supported by the records.

FINDING #2

The case may have a defendant-identity problem before it has a fraud problem.

WHY IT MATTERS

The billing export identifies an NPI and Bayview Medical Center, but the legal entity that submitted the Medicare claims is not confirmed.

SOURCES

SOURCE · `billing_export_q4_2017.csv`

ATTORNEY NEXT STEP

Search NPPES and confirm the Medicare billing entity before drafting any complaint.

FINDING #3

The damages estimate is not usable yet.

WHY IT MATTERS

The relator calculated a rough damages figure, but the report separates total billing from actual government overpayment. Without Medicare payment data, the damages number cannot be relied on.

SOURCES

SOURCE · `handwritten_notes_scan.txt`

ATTORNEY NEXT STEP

Obtain Medicare 835 remittance files and data showing which claims were paid by Medicare, Medicaid, or private insurance.

FINDING #4

The internal knowledge timeline has a contradiction.

WHY IT MATTERS

One record suggests compliance flagged the issue in 2016, while another suggests leadership later said the issue was not systemic. That conflict affects knowledge, good faith, and institutional response.

SOURCES

SOURCE · `handwritten_notes_scan.txt`

SOURCE · `forwarded_complaint_email.txt`

ATTORNEY NEXT STEP

Obtain the 2016 compliance memo and Holloway's review notes.

FINDING #5

The file looks more complete than it is.

WHY IT MATTERS

Key documents are referenced, but not actually present in the evidence set. The case cannot be treated as complete until those documents are obtained.

SOURCES

SOURCE · `document inventory · cross-referenced with missing-evidence section`

ATTORNEY NEXT STEP

Request reimbursement_summary_2016_2017.txt, quarterly_audit_excerpt_2017.txt, and the full Chen email thread.

Attorney action. Review, challenge, and approve before any of this is used for a legal purpose. Tellcrest output is a review assistant. It does not replace attorney judgment.