Department of Law, Criminal Division
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IN THE DISTRICT COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

STATE OF ALASKA,

Plaintiff,

vs.

JOHN D. ZIPPERER, JR.
DOB: 04/22/1970
APSIN ID: 7647492
DMV NO.: 7403716 AK
ATN: 115745346

JOHN D. ZIPPERER, JR. MD LLC
APSIN ID: 9183056
ATN: 115745355

Defendants.

No. 3AN-19-_____ CR (John D. Zipperer, Jr.)
No. 3AN-19-_____ CR (John D. Zipperer, Jr. MD LLC)

INFORMATION

I certify this document and its attachments do not contain the (1) name of a victim of a sexual offense listed in AS 12.61.140 or (2) residence or business address or telephone number of a victim of or witness to any offense unless it is an address identifying the place of a crime or an address or telephone number in a transcript of a court proceeding and disclosure of the information was ordered by the court. The following counts charge a crime involving DOMESTIC VIOLENCE as defined in AS 18.66.990:

Count I - AS 47.05.210(a)(1)
Medical Assistance Fraud
John D. Zipperer Jr. and John D. Zipperer Jr. MD LLC- 001

Count II - AS 47.05.210(a)(4)
Medical Assistance Fraud
John D. Zipperer Jr. and John D. Zipperer Jr. MD LLC - 002

Count III - AS 11.56.790(a)(1)
Compounding
John D. Zipperer Jr. and John D. Zipperer Jr. MD LLC - 003

THE OFFICE OF SPECIAL PROSECUTIONS CHARGES:

COUNT I

That in the Third Judicial District, State of Alaska, on or about August 2013 - September 2015, at or near Anchorage, JOHN D. ZIPPERER JR, and JOHN D. ZIPPERER JR MD LLC, as principal and accomplice, knowingly submitted or authorized the submission of a claim to a medical assistance agency for property, services, or a benefit with reckless disregard that the claimant is not entitled to the property, services, or benefit, and the value of the property, services, or benefit is over $25,000.

All of which is a Class B Felony offense being contrary to and in violation of AS 47.05.210(a)(1) and against the peace and dignity of the State of Alaska.

COUNT II

That in the Third Judicial District, State of Alaska, on or about October 2018 - December 2019, at or near Anchorage, JOHN D. ZIPPERER JR., failed to produce medical assistance records to a person authorized to request the records; to wit: refusing to provide documents for the Qlarant audit.

All of which is a Misdemeanor class A offense being contrary to and in violation of AS 47.05.210(a)(4) and against the peace and dignity of the State of Alaska.

COUNT III

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That in the Third Judicial District, State of Alaska, on or about 2015, at or near Anchorage, JOHN D. ZIPPERER JR., conferred, offered to confer, or agreed to confer a benefit on another in consideration of that other person's concealing an offense, refraining from initiating or aiding in the prosecution of an offense or withholding evidence of an offense; to wit: offering $150,000 to a former employee for that employee's statement about the medical necessity of the urine testing scheme.

All of which is a Misdemeanor class A offense being contrary to and in violation of AS 11.56.790(a)(1) and against the peace and dignity of the State of Alaska.

The undersigned swears under oath this Information is based upon a review of police report 0634501 and audit finalized December 4, 2019, submitted to date.

1. Medicaid Background

This Medicaid fraud case arose from numerous complaints to the Alaska Medical Board and is the culmination of an extensive investigation involving many State and Federal agencies. In order to submit claims to Medicaid for services, physicians or any other qualifying healthcare professional must enroll in Medicaid, either individually or through a larger corporation or hospital. The physician, as an "enrolled provider," must sign an initial contract and periodically affirm to Medicaid that the services for which they submit claims are medically necessary services, and also affirm their understanding that submitting claims for medically unnecessary services may constitute criminal fraud. Providers are prohibited from submitting claims to Medicaid for medically unnecessary services. If Medicaid discovers that the provider has been submitting claims to Medicaid

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for medically unnecessary services, the provider can be subject to criminal prosecution for fraud. Similarly, Medicaid will only pay for services, and providers may only submit claims for services, that the provider actually performs.

Medicaid relies on a "pay and chase" system common in the insurance industry, wherein Medicaid will often pay for claims because a physician, company, or hospital affirms the medical necessity of and accuracy of the individual services for which they submit claims. If Medicaid later determines that it overpaid a provider, such as discovering that the services the agency reimbursed the provider for were medically unnecessary or did not happen, Medicaid may pursue the matter administratively or criminally. Overpayment determinations may occur through random audits, self-reporting, witness tips, or as in this case, patient complaints that lead to criminal investigations.

A medical provider submits claims to Medicaid, and most other insurance companies, using the Current Procedural Terminology, or "CPT," code set maintained by the American Medical Association. Each specific medical service has one or more corresponding five digit CPT codes. For instance a provider may submit a claim for an appendectomy under CPT code 44950, or a substance abuse screening under CPT code 99409, or a non-emergency ambulance transport under CPT code A0428. These CPT codes are ubiquitous throughout the insurance and medical industries.

The rate at which a physician, corporation, or hospital bills for an individual claim submitted to Medicaid is often not the same rate at which Medicaid reimburses. A provider can submit a claim to Medicaid, or anyone else, at whatever billed rate they

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wish, subject to limitations not relevant to this case. Medicaid; however, typically has a specific rate at which they reimburse for each specific CPT code. For example, a physician may submit a claim to every insurance company, including Medicaid, in the amount of $1,000 for CPT code X0123. If Medicaid only reimburses $90 for CPT code X0123; however, Medicaid will only reimburse that physician $90 for that submitted claim. Different insurance companies may reimburse different rates for any individual CPT code. Thus, while providers typically do not increase their Medicaid revenue by increasing the billed amount per CPT code, one way for a physician to commit Medicaid fraud and fraudulently increase their Medicaid revenue is to artificially increase the number of CPT codes for which they bill. A physician may do this either by performing numerous medically unnecessary services, simply submitting claims for services they never actually provide, or duplicating the services or claims they submit to Medicaid.

Additionally, a provider may be enrolled in Medicaid either directly or as a servicing provider. For instance, a physician provider at a small office may be enrolled personally with Medicaid and may bill Medicaid directly. Or a provider may be enrolled as an employee of a larger organization. For instance, a physician working at a large hospital would routinely be enrolled with Medicaid such that the services the he or she provides are billed to Medicaid under the hospital's name. In such a situation, the hospital would be paid directly by Medicaid, and the provider would be noted as the "servicing provider."

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2. Dr. Zipperer Background

Dr. John D. Zipperer, Jr. owns and operates Zipperer Medical Group, John D. Zipperer Jr., MD LLC (incorporated in Alaska), John D. Zipperer, Jr. MD LLC (incorporated in Tennessee), and Pain and Addiction Centers of America (collectively "ZMG"). Dr. Zipperer and his corporations have been enrolled in the Alaska Medicaid program since August 2010, when he moved to Alaska from Georgia. Dr. Zipperer worked as an internist with Mat-Su Regional Medical Center until transitioning into his own pain management practice in June-August 2012. Dr. Zipperer's first clinic opened in Wasilla, and he later expanded his company's operations to Fairbanks, Anchorage, Soldotna, Eagle River, as well as Tennessee, California, and possibly other states. Dr. Zipperer would bill Medicaid personally, and would also have his enrolled servicing provider employees bill Medicaid through his corporation and by his direction.

While the number of ZMG's employees varied, at any given time about one to four other enrolled providers worked for Dr. Zipperer, as well as several non-enrolled medical assistants, nurses, and other staff. Dr. Zipperer wholly owned all of his corporations, personally directed which tests his company and his employees ran, personally directed how his company and his employees submitted claims to Medicaid, and personally profited either the entire reimbursed amount or a large percentage of the reimbursed amount. Dr. Zipperer used John D. Zipperer, Jr. MD LLC as the servicing provider for all of his illegal billing, and at all relevant times herein the employees, including Dr. Zipperer, were agents of the corporation and all billing was done through the corporation profiting Dr. Zipperer personally.

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Dr. Zipperer's practice consisted largely of pain management and outpatient opiate addiction treatment, with a small amount of general family medicine. Many of Dr. Zipperer's patients were Medicaid patients, and he also had patients with Blue Cross Blue Shield, Aetna, Medicare, insurance though the Alaska Electrical Trust Fund, and many other insurance companies. Dr. Zipperer's business model focused on seeing his patients very regularly, sometimes as often as every three days, for months or years at a time.

3. The Fraudulent Scheme, Testing for Profit Using Unnecessary Tests – Count I

At each and every office visit, Dr. Zipperer would require his patients to submit a urine sample. He would require his patients to submit these samples regardless of diagnosis, regardless of how much time elapsed since the last urine sample, regardless of which providers they saw, and regardless of the purpose of the visit. Each urine sample would then be sent to his personally owned laboratory, located in Tennessee, where the samples were needlessly subjected to dozens of tests. Dr. Zipperer would then submit claims to Medicaid (or other insurance companies, or the cash-paying patients personally) approximately $4,000-$8,000 *per* urine sample. Dr. Zipperer would submit claims to Medicaid using about two dozen CPT codes for tests he ran on the urine samples at his Tennessee lab. Medicaid reimbursed Dr. Zipperer approximately 10-20% of what he billed per urine sample, while other insurance companies would reimburse more, and cash paying patients would be stuck with the whole bill. Medicaid patients rarely, if ever, saw their bills or had any idea what tests Dr. Zipperer was running on their biological

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samples. Medicaid patients typically do not receive an "Explanation of Benefits," and the Medicaid patients going to Dr. Zipperer had no idea the amount of money he profited from their biological samples.

This case arose when a number of Dr. Zipperer's cash-paying patients complained to the Medical Board when they received surprise medical bills after basic routine office visits. For example, one patient received a $21,000 bill for laboratory tests Dr. Zipperer performed on her urine samples without her knowledge or understanding. She complained that Dr. Zipperer did not tell her the purpose of the urine test, or the tests that were going to be performed, nor did she ever expect such an expensive test in conjunction with the routine nature of her visit.

A. Timeline of Events - Opening His Alaska clinic and Tennessee Lab; Order of Testing

Beginning in July of 2012, as he opened his clinic in Wasilla, Dr. Zipperer began increasing the total number of services and monetary amount of claims he submitted to Medicaid, with a coinciding increase in the value of Medicaid reimbursement. In June-July 2012, Dr. Zipperer submitted claims to Medicaid for zero or minimal laboratory services. By the end of 2012, Dr. Zipperer was submitting more claims to Medicaid for laboratory services than any other similarly situated physician in Alaska.

For the calendar year 2012, Dr. Zipperer (through ZMG) submitted claims to Medicaid totaling approximately $216,000 and was reimbursed approximately $35,000 for CPT codes related to laboratory services. From January – July 2013; however, Dr. Zipperer submitted claims to Medicaid totaling approximately $1.5 million for

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laboratory services and was reimbursed approximately $240,000. Until July 2013, Dr. Zipperer used third party laboratory testing companies to test the urine samples from his patients. The allegations in this case focus on Dr. Zipperer submitting claims to Alaska Medicaid for laboratory services performed at his Tennessee lab from August 2013 – September 2015.

In August 2013, Dr. Zipperer opened his own urine testing lab in Tennessee, using the company John D. Zipperer, Jr. MD LLC. Dr. Zipperer designed the Tennessee urine testing lab to personally direct and maximize the number of tests he could perform on the urine samples, to personally direct and maximize the value of the claims he submitted to Medicaid and other insurance companies, and to personally direct and maximize his personal profits for the urine testing scheme.

Beginning in August 2013, Medicaid saw a significant increase in submitted claims from Dr. Zipperer. From August – December 2013, Dr. Zipperer submitted claims to Medicaid valued at approximately $21.1 million for laboratory services and was reimbursed about $1.2 million. For the total year 2014, Dr. Zipperer submitted claims to Medicaid valued at approximately $31.3 million for laboratory services and was reimbursed approximately $2.8 million. From January – September 2015, Dr. Zipperer submitted claims to Medicaid valued at approximately $16.6 million for laboratory services and was reimbursed approximately $5 million. Both the dollar amount associated with the claims submitted to Medicaid and the amount reimbursed by Medicaid for laboratory services was over ten times greater than the entire combined total of all other providers in the Alaska Medicaid program for laboratory test CPT codes during that time

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period. This total was in addition to the large amounts of money Dr. Zipperer was being paid by other insurance companies for these laboratory tests, as well as the money he was being paid from cash-paying patients who were being charged the full amounts for all of the laboratory tests.

Beginning in 2015 Medicaid and other insurance companies began catching on to the laboratory testing scheme. The insurance companies, including Medicaid, began dis-enrolling him and/or refusing payment. Dr. Zipperer's reimbursement eventually began decreasing, leading to him winding down the Tennessee lab operations in September 2015. After about August 2015 Dr. Zipperer's total Medicaid laboratory bills and reimbursement fell to approximately zero.

The laboratory tests Dr. Zipperer performed on the urine samples can be separated into three phases based on order of testing. In the first phase, Dr. Zipperer would perform a conventional urine cup test by using a "point of care" (POC) cup, also known as a "dip stick test," "UDT," or "instant read cup." This test would be performed by having the patient urinate into a small plastic cup in the clinic in Alaska. The cups are widely available and recognizable, can be purchased from medical supply companies or Walgreens or Amazon, and typically have instant-read mechanisms similar to "dip stick" tests. While the POC cup testing panel varied slightly by brand, the POC cup instantly screened a patient's urine for about 12 classes of drugs, including Amphetamines, Barbiturates, Marijuana, Opiates, etc. The screening tests would indicate either a positive or negative result for each class of drug. The results were instantaneous and used by the

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provider at that specific visit. All or very nearly all of Dr. Zipperer's patients were required to urinate in a cup when they came to his clinic at each and every visit.

In the second phase, Dr. Zipperer's employees would seal the POC cups, package them in bulk shipments, and FedEx them to Dr. Zipperer's Tennessee lab. The lab would then run a second set of screening tests on the urine in the cups, repeating the first test. While Dr. Zipperer periodically changed his testing panel, this second screening test would re-screen the urine for the same 12 categories of drugs, including Amphetamine, Barbiturates, Marijuana, Opiates, etc. This second screening test would also indicate either a positive or negative result for each class of drug, thus duplicating the first test. This second set of screening tests is referred to in the industry as "qualitative" testing. This second test was typically identical, or at least nearly identical, to the "dip-stick" testing, except that it was performed in 12 individual steps repeating the one all-inclusive "dip-stick." These second tests were largely ignored by Dr. Zipperer and were not used for any clinical purpose. The second tests were done purely for profit and not for any diagnosis or treatment planning whatsoever. The manner in which Dr. Zipperer split up the second tests fraudulently increased the number of CPT codes he submitted to Medicaid.

In the third phase, Dr. Zipperer would then subject the urine to another round of testing to "confirm" every single result from the first two screening tests, regardless of whether the first two tests were positive or negative. The confirmatory testing panel also changed over time, but a typical panel included about 20-30 confirmatory tests. Each confirmatory test looked for a specific drug in the category of drugs on a screening test,

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such that each classification of drug screened for would have about three specific sub-compounds confirmed. The third test would come back with a specific number reporting the specific concentration of that drug, as opposed to a simple positive or negative. For example, after the first and second screening tests came back negative for barbiturates, Dr. Zipperer would then "confirm" that negative result by "confirming" the specific level of zero for phenobarbital, secobarbital, butalbital, and pentobarbital in order to "confirm" that there were no barbiturates in the patient's urine. This third set of testing is referred to in the industry as "confirmation" or "quantitative" testing. The third testing phase was done without any individualized justification or rationale, and therefore without any medical necessity, and was done purely to maximize the number of tests Dr. Zipperer could perform at his Tennessee lab for are pure profit-driven motive.

B. The Tests Dr. Zipperer Ran and the CPT Codes He Billed to Medicaid

Until January 2015, Dr. Zipperer submitted claims to Medicaid for each of the 12 individual screening tests done at his Tennessee lab. He would submit these claims using CPT code 80101. Dr. Zipperer would submit, for instance, 10 separate 80101 codes claims at $101 dollars each. He would not submit a claim for the much cheaper all-inclusive "dip-stick" test he had done in the clinic. This came out to a total of, typically, $1,010 claim submitted *per* urine cup just for the second duplicate screening test. Medicaid would reimburse each 80101 at $19.72 each.

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Then Dr. Zipperer would file a claim for each of the 20-30 individual "confirmation" tests, at $30-$6200 each. Medicaid reimbursed each of those confirmation tests at different rates.

The following is a typical example of a typical panel, using the 2014 CPT codes, for which Dr. Zipperer would submit a claim to Medicaid and the reimbursement rate:

CPT	CPT Description	Billed	Reimbursed
80101	**DRUG SCREEN**	$1,010.00	$197.20
80154	**BENZODIAZEPINES LEVEL**	$240.00	$50.46
80299	**QUANTITATION OF THERAPEUTIC DRUG**	$126.95	$18.68
81003	**URINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE, HEMOG**	$32.00	$3.06
82055	**ALCOHOL (ETHANOL) LEVEL**	$113.00	$14.74
82145	**AMPHETAMINE OR METHAMPHETAMINE LEVEL**	$184.00	$21.20
82205	**BARBITURATES LEVEL**	$137.25	$15.62
82492	**CHEMICAL ANALYSIS**	$620.00	$49.26
82520	**COCAINE (DRUG) LEVEL**	$179.00	$20.68
82542	**CHEMICAL ANALYSIS USING CHROMATOGRAPHY TECHNIQUE**	$156.00	$24.63
82570	**CREATININE; OTHER SOURCE**	$70.00	$7.06
82646	**DIHYDROCODEINONE (DRUG) MEASUREMENT**	$247.56	$28.17
82649	**DIHYDROMORPHINONE (DRUG) LEVEL**	$308.16	$35.07
82742	**FLURAZEPAM (DRUG) LEVEL**	$130.00	$27.00
83789	**MASS SPECTROMETRY (LABORATORY TESTING METHOD)**	$430.56	$49.26
83805	**MEPROBAMATE (SEDATIVE) LEVEL**	$211.29	$24.04
83840	**METHADONE LEVEL**	$135.00	$22.28
83925	**OPIATES (DRUG) MEASUREMENT**	$500.00	$106.16
83986	**PH; BODY FLUID, NOT OTHERWISE SPECIFIED**	$30.00	$4.88
84311	**SPECTROPHOTOMETRY, ANALYTE NOT ELSEWHERE SPECIFIED**	$50.00	$9.54

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As previously stated, the testing panel changed over time, and the CPT codes changed over time, and this represents a typical panel. In that way, Dr. Zipperer would submit a claim to Medicaid for $4,910.52 for each urine sample he collected.

In January 2015 the CPT codes were overhauled. At that time, Dr. Zipperer stopped performing the second screening test in his Tennessee lab, and likewise stopped submitting the 80101 claims. The following is a typical example of a typical panel, using the 2015 CPT codes, for which Dr. Zipperer would submit a claim to Medicaid:

CPT	CPT Description	Billed	Reimbursed
80184	**PHENOBARBITAL**	$138.00	$15.58
80299	**QUANTITATION OF THERAPEUTIC DRUG**	$130.00	$18.64
80301	**DRUG SCREEN**	$317.00	$253.60
80320	**ALCOHOLS LEVELS**	$115.00	$92.00
80326	**AMPHETAMINES LEVELS**	$368.00	$294.40
80345	**BARBITURATES LEVELS**	$115.00	$92.00
80346	**BENZODIAZEPINES LEVELS**	$120.00	$96.00
80348	**BUPRENORPHINE LEVEL**	$160.00	$128.00
80353	**COCAINE LEVEL**	$130.00	$104.00
80354	**FENTANYL LEVEL**	$310.00	$248.00
80356	**HEROIN METABOLITE LEVEL**	$216.00	$172.80
80358	**METHADONE LEVEL**	$140.00	$112.00
80359	**METHYLENEDIOXYAMPHETAMINES LEVELS**	$184.00	$147.20
80361	**OPIATES LEVELS**	$248.00	$198.40
80362	**OPIOIDS LEVELS**	$310.00	$248.00
80365	**OXYCODONE LEVELS**	$130.00	$104.00
80369	**SKELETAL MUSCLE RELAXANTS LEVELS**	$310.00	$248.00
80372	**TAPENTADOL LEVEL**	$216.00	$172.80
80373	**TRAMADOL LEVEL**	$130.00	$104.00
81003	**Urinalysis, by dip stick or tablet reagent**	$64.00	$3.06
82570	**CREATININE; OTHER SOURCE**	$140.00	$4.04
83986	**PH; BODY FLUID, NOT OTHERWISE SPECIFIED**	$60.00	$4.87
84311	**SPECTROPHOTOMETRY, ANALYTE NOT ELSEWHERE SPECIFIED**	$110.00	$9.52

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Comparing the data from the Tennessee lab with the Medicaid billing data showed that Dr. Zipperer would submit a bill to Medicaid for one 80101 per drug category, and then one confirmatory code for the group of confirmation tests under that drug category. For instance, using the 2014 CPT codes, Dr. Zipperer submitted a claim for one of the ten 80101 CPT codes for barbiturate screening, and then one 82205 CPT code to confirm that barbiturate result by testing for phenobarbital, secobarbital, butalbital, and pentobarbital.

The State obtained data from Dr. Zipperer's Tennessee lab operation. Dr. Zipperer saw 1,949 patients whose urine was sent to the Tennessee lab. These 1,949 patients had their urine cups sent to the lab 20,787 individual times, reflecting that each patient visited him approximately 10 times during the scheme. Dr. Zipperer ordered 1,074,035 individual tests. While the panel changed over time, the most commonly conducted tests were performed for patients in 18,870 to 20,647 of the 20,787 visits. The least common tests were conducted in 305 to 343 visits. There were 36 quantitative tests that were performed 18,870 times or more out of the 20,787 visits. The main qualitative test panel, consisting of 10-12 different screening tests, was performed on 12,544 visits until Dr. Zipperer stopped screening at the Tennessee lab in January 2015. With very few exceptions, Dr. Zipperer would order the exact same test panel for all patients, then slightly change the panel and order that same test panel for all patients, and then again slightly change the panel, and order that same test panel for those patients, and so on. At no point was Dr. Zipperer ordering tests for his patients on a personalized or individualized basis.

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The most commonly conducted tests included, just as examples, secobarbital testing, tapentadol testing, MDMA testing, and meprobamate testing. Of the 19,641 times Dr. Zipperer tested for secobarbital, zero patients tested positive. Of the 19,941 times Dr. Zipperer tested for tapentadol, two patients tested positive.

One witness stated that she observed Dr. Zipperer stockpiling urine samples in fridges in his office during a time period just before his lab opened. The data from the lab operation shows that for the months of August-September 2013, nearly all of the urine samples Dr. Zipperer collected were not analyzed at the lab until approximately 20-40 days elapsed after their collection date, corroborating that witness's statement that Dr. Zipperer was stockpiling urine during that time. Despite submitting a claim to Medicaid for these lab tests as if they were medically necessary, some patients went through several visits while Dr. Zipperer was collecting their urine and stockpiling fridges and freezers full of urine cups so that he could send it to his own personal lab and maximize his profit. This resulted in Dr. Zipperer sending a large quantity of urine to his Tennessee lab in September-October 2013, as well as submitting a large quantity of Medicaid claims in October 2013.

4. Response of the State, and Zipperer's Repeated Failure to Comply with Audit

Medical necessity is defined in 7 AAC 105.100 as the standards of practice applicable to the provider. The American Medical Association defines medical necessity as "Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its

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symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider. The 'prudent physician' standard of medical necessity ensures that physicians are able to use their expertise and exercise discretion, consistent with good medical care, in determining the medical necessity for care to be provided each individual patient."

When Medicaid and the other insurance companies began catching on to the scheme, the Alaska Medicaid program began auditing some of Dr. Zipperer's claims for medical necessity. As part of this type of audit, Alaska Medicaid personnel would stop payment on a small number of claims and then ask the provider to justify the medical necessity of those claims. When this began occurring for Dr. Zipperer's laboratory testing claims, Dr. Zipperer called the Alaska Medicaid office many times to argue with Alaska Medicaid personnel. Those personnel repeatedly told Dr. Zipperer that he could only bill Alaska Medicaid for medically necessary services, and that it was his responsibility to be able to justify that medical necessity. Those personnel also told Dr. Zipperer that industry standard for laboratory testing is to do "reflex confirmation," which Dr. Zipperer was clearly not doing. Those personnel reported to investigators that Dr. Zipperer would yell and scream at them. Dr. Zipperer never attempted to justify the medical necessity of his urine testing scheme. After this audit period, which lasted for several months, Alaska Medicaid adopted a more strict payment procedure for the laboratory tests and

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Dr. Zipperer's reimbursement decreased. After the policy change, in the time period around September-October 2015, Dr. Zipperer withdrew from Alaska Medicaid.

Dr. Zipperer's clinic occasionally employed other doctors. Dr. Zipperer's physician employees also refused to participate in the scheme. One physician employee accounted for many of the patient visits where the patient did not get the full testing panel because that physician employee did not see any necessity to doing a full testing panel on a patient. In other words, that physician employee of Dr. Zipperer refused to order medically unnecessary urine tests for her patients. As a result of this, Dr. Zipperer yelled and screamed at her in front of the office staff and fired her. Another physician employee of Dr. Zipperer quit working at ZMG (Count III), and he stated that Dr. Zipperer offered him $150,000 if he would sign a document stating that everything he saw at ZMG was medically necessary. That physician employee told investigators he thought he was being offered a bribe, and refused to sign anything and refused to take the money.

The State contacted a medical doctor and expert on pain management to serve as an expert consultant. This expert is board certified, has her own urine toxicology and genetic testing lab in Florida, has over 80 peer-reviewed papers on the subject of pain management, and has testified in Congress on the subject of the opioid epidemic. She reviewed a number of records from Dr. Zipperer's office and also ended up treating many of Dr. Zipperer's patients who left his practice. She concluded that most if not all areas of Dr. Zipperer's practice were significantly problematic. With respect to urine testing at the Tennessee lab, she concluded that he was testing for profit, testing without clinical utilization, testing without medical necessity, that his charges for urine testing were far

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and away higher than anyone else's, and that his urine testing scheme was gross malpractice and motivated by greed.

In late 2018, Alaska Medicaid began conducting a formal audit of Dr. Zipperer's claims through Medicaid's audit subcontractor Qlarant (Count II). Qlarant was auditing Dr. Zipperer to review whether the submitting claims were supported by sufficient documentation, including documentation of medical necessity. As part of any provider's Medicaid enrollment agreement, that provider agrees to the audit process and agrees that failure to cooperate with the audit process will lead to overpayment findings and possible criminal prosecution. The law also requires that providers cooperate with audits, including providing to auditors the medical records they are required to keep underlying their claims. Throughout 2019, Qlarant repeatedly invited Dr. Zipperer to cooperate in the mandatory audit process. Dr. Zipperer refused to cooperate with the Qlarant audit process and refused to turn over the medical records underlying the millions of dollars of claims he submitted, causing significant delays in finalizing the audit. On December 4, 2019, after continued refusal to cooperate with the audit, the Department of Health and Social Services formally sanctioned Dr. Zipperer by dis-enrolling him and requiring that he pay back $8,813,333.39 to the Alaska Medicaid program.

BAIL INFORMATION

Per the Alaska Public Safety Information Network, the defendant has the following convictions in Alaska: The defendant has no criminal history. The State believes he lives and works out of State, however he may have local counsel.

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Commensurate with other recent MFCU cases, the State requests a summons with appropriate appearance bail, including ankle monitor, set at arraignment.

Dated at Anchorage, Alaska, this ____ day of December, 2019.

KEVIN G. CLARKSON
ATTORNEY GENERAL

By: _____
Eric Senta
Assistant Attorney General
Alaska Bar No. 1011091

Search warrant numbers:
3AN-16-1858SW 3AN-16-1286SW
3AN-16-1297SW 3AN-16-1283SW
3AN-16-1296SW 3AN-16-1917SW
3AN-16-1291SW

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