UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

UNITED STATES OF AMERICA	)	
***ex rel.* UNDER SEAL**	)	**Civil Action No. 2:17-cv-2291-PMD**
v.	)	
	)	**FILED UNDER SEAL**
DEFENDANT UNDER SEAL	)	
	)	**JURY TRIAL DEMANDED**

AMENDED COMPLAINT FOR FALSE CLAIMS ACT VIOLATIONS 31 U.S.C. § 3729, ET SEQ.

John S. Simmons, Federal ID No. 5000
jsimmons@simmonslawfirm.com
Derek A. Shoemake, Federal ID No. 10825
dshoemake@simmonslawfirm.com
John L. Warren, Federal ID No. 12164
jwarren@simmonslawfirm.com
Simmons Law Firm, LLC
1711 Pickens Street
Columbia, SC 29201
Telephone: 803-779-4600

Herbert W. Louthian Jr., Federal ID No. 2729
bert@louthianlaw.com
Louthian Law Firm, PA
P.O. Box 1299
Columbia, SC 29202
Telephone: 803-454-1200

Fran Trapp, Federal ID No. 6376
fran@billnettleslaw.com
2008 Lincoln Street
Columbia, SC 29201
Telephone: 803-814-2826
Counsel for Relators

UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

UNITED STATES OF AMERICA *ex rel.* DANA DOVE AND DEBBIE RATHBUN,	)	
Plaintiff,	)	**Civil Action No. 2:17-cv-2291-PMD**
v.	)	
	)	**FILED UNDER SEAL**
UCI MEDICAL AFFILIATES, INC., UCI MEDICAL AFFILIATES OF SOUTH CAROLINA, INC., AND DOCTORS CARE, P.A.	)	**JURY TRIAL DEMANDED**
Defendants.	)	

I. INTRODUCTION

1. This action arises under 31 U.S.C. §§ 3729 *et seq.*, also known as the False Claims Act ("FCA"), to recover treble damages and civil penalties on behalf of the United States of America, arising out of Defendants' violations of the FCA.

2. As more fully alleged herein, this action arises out of a scheme to defraud the United States of America, perpetrated by the Defendants, commencing as early as 2014 and continuing to present as an ongoing scheme. The Defendants made and/or caused to be made to the United States, false claims for payment of medical services. First, Defendants submitted claims to Medicare, Medicaid, Medicaid Managed Care Organizations, Medicare Advantage, TRICARE, and other federal health insurance programs ("Federal Healthcare Programs") for services that were provided by physicians and Nurse Practitioners and Physician Assistants ("mid-

levels") that were not credentialed as providers for the respective Federal Healthcare Programs. Defendants accomplished this by billing the services of non-credentialed providers under the NPI number and signature of various credentialed providers (who took no part in providing the care that was billed for). Second, Defendants violated the "incident to" billing guidelines of the Federal Healthcare Programs and sought higher reimbursements for midlevels despite the fact that physicians took no part in the midlevels' treatment. Third, Defendants violated the "incident to" billing guidelines of the Federal Healthcare Programs by billing new patient visits provided by midlevels under the signature of physicians who took no part in the treatment. Fourth, Defendants submitted false and fraudulent claims for various medications and medical equipment. Finally, Defendants submitted false and fraudulent claims for Medicare Annual Wellness Visits.

3. These acts constitute violations of the FCA, which provides, *inter alia*, that any person who knowingly presents and/or causes to be presented to the United States a false or fraudulent claim for payment is liable for a civil penalty for each claim, plus three times the amount of the damages sustained by the Government. The FCA also allows any person discovering a fraud perpetrated against the Government to bring an action for himself and for the Government and to share in any recovery. 31 U.S.C. § 3730.

4. As required by the FCA, 31 U.S.C. § 3730(b)(2), Relators have provided to the Attorney General of the United States and to the United States Attorney for the District of South Carolina a statement of all material evidence and information related to the Complaint. This disclosure statement is supported by material evidence known to Relators. Because the disclosure statement includes attorney-client communications and work product of Relators' attorneys, and is submitted to the Attorney General and to the United States Attorney in their capacity as potential co-counsel in the litigation, the Relators understand this disclosure to be confidential.

II. JURISDICTION AND VENUE

5. Relators re-allege and incorporate the allegations of the paragraphs above as if fully set forth herein.

6. This action arises under the FCA, 31 U.S.C. §§ 3729 *et seq.* This Court has jurisdiction over this case pursuant to 31 U.S.C. §§ 3732(a) and 3730(b). This Court also has jurisdiction pursuant to 28 U.S.C. § 1345 and 28 U.S.C. § 1331.

7. The Court may exercise personal jurisdiction over the Defendants under 31 U.S.C. § 3732(a) because each of the Defendants resides in the District of South Carolina, transacts business in this district, or previously transacted business in this district.

8. Venue is proper in this District pursuant to 31 U.S.C. § 3732(a), because acts proscribed by 31 U.S.C. §§ 3729 *et seq.* and complained of by any one of Defendants herein took place in this District and throughout the United States, and is also proper pursuant to 28 U.S.C. § 1391(b) and (c), because at all times material and relevant, Defendants transact and transacted business in this District.

III. PARTIES

9. Relators re-allege and incorporate the allegations of the paragraphs above as if fully set forth herein.

A. Relator Dana Dove

10. Relator Dana Dove ("Relator Dove") is a citizen of the United States and resident of the State of South Carolina.

11. Relator Dove is a certified medical coder, auditor, and compliance officer with over thirteen years of experience in medical insurance, billing, coding, and management. Specifically, Relator Dove is a Certified Professional Coder, Certified Outpatient Coder, Certified Cod-

ing Associate, Certified Professional Medical Auditor, Certified Professional Compliance Officer, and Certified Revenue Cycle Associate.

12. Relator Dove is currently employed by Defendant UCI Medical Affiliates, Inc. and Defendant UCI Medical Affiliates of South Carolina, Inc. (collectively, "UCI Defendants") as a certified coding specialist and auditor.

13. Relator Dove brings this action based on her direct, independent, and personal knowledge and also on information and belief.

14. Relator Dove is an original source of this information to the United States and has voluntarily provided this information to the United States prior to filing this Complaint.

B. Relator Debbie Rathbun

15. Relator Debbie Rathbun ("Relator Rathbun") is a citizen of the United States and resident of the State of South Carolina.

16. Relator Rathbun is a healthcare management specialist with over twenty years of experience in healthcare accounting, financial analysis, and provider/payer contracting.

17. Relator Rathbun is currently employed by the UCI Defendants as a third-party payer contract negotiator/analyst and credentialing supervisor.

18. Relator Rathbun brings this action based on her direct, independent, and personal knowledge and also on information and belief.

19. Relator Rathbun is an original source of this information to the United States and has voluntarily provided this information to the United States prior to filing this Complaint.

C. Plaintiff United States

20. The United States of America (hereinafter “United States”), through its agency, the Department of Health and Human Services (hereinafter “HHS”) and, specifically the Health

Care Financing Administration (hereinafter "HCFA"), now known as the Center for Medicare and Medicaid Services (hereinafter "CMS"), administers the Medicare program to provide health insurance for the elderly and the disabled and the Medicaid program to provide health insurance to individuals whose income and resources are insufficient to pay for healthcare. The United States, through the Department of Defense and Defense Health Agency, also administers the TRICARE Program.

D. Defendant UCI Medical Affiliates, Inc.

21. Defendant UCI Medical Affiliates, Inc. is a foreign corporation organized and existing under the laws of the State of Delaware that is authorized to do business in the State of South Carolina.

22. Upon information and belief, Defendant UCI Medical Affiliates, Inc.'s principal place of business is 1818 Henderson Street, Columbia, South Carolina 29201.

23. Upon information and belief, Defendant UCI Medical Affiliates, Inc. is a holding company that owns an operating subsidiary, Defendant UCI Medical Affiliates of South Carolina, Inc.

24. Through this subsidiary, Defendant UCI Medical Affiliates provides management, administrative, and billing services to the approximately fifty urgent care facilities operated by Defendant Doctors Care, P.A. in South Carolina.

25. Upon information and belief, BlueCross BlueShield of South Carolina ("BCBS" owns a majority share of Defendant UCI Medical Affiliates, Inc.

26. Upon information and belief, the success and revenue of Defendant UCI Medical Affiliates, Inc. greatly benefits BCBS's insurance business because urgent care visits for BCBS insured patients are less costly than emergency room visits.

27. Upon information and belief, Defendant UCI Medical Affiliates, Inc. has encountered a number of serious issues in the past. For example, its former CFO—Jerry F. Wells, Jr.—pled guilty to embezzling approximately $3 million from Defendant UCI Medical Affiliates, Inc. by misusing corporate funds for personal expenses. Mr. Wells was sentenced to six and one-half years in federal prison.

E. Defendant UCI Medical Affiliates of South Carolina, Inc.

28. Defendant UCI Medical Affiliates of South Carolina, Inc. is a corporation organized and existing under the laws of the State of South Carolina with its principal place of business being located at 1818 Henderson Street, Columbia, South Carolina 29201.

29. Upon information and belief, Defendant UCI Medical Affiliates of South Carolina, Inc. is an operating subsidiary of Defendant UCI Medical Affiliates, Inc.

30. Upon information and belief, Defendant UCI Medical Affiliates of South Carolina, Inc. provides management, administrative, and billing services to the approximately fifty urgent care facilities operated by Defendant Doctors Care, P.A. in South Carolina.

F. Defendant Doctors Care, P.A.

31. Defendant Doctors Care, P.A., is a corporation organized and existing under the laws of the State of South Carolina.

32. Upon information and belief, Defendant Doctors Care, P.A. operates approximately fifty doctors offices across the State of South Carolina.

33. Upon information and belief, Defendant Doctors Care, P.A. primarily provides outpatient urgent care services to patients as an alternative to emergency rooms.

34. Upon information and belief, Defendant Doctors Care, P.A. is the largest urgent care company in South Carolina.

35. Upon information and belief, Defendant Doctors Care, P.A. contracts with the UCI Defendants, and the UCI Defendants provide, *inter alia*, nonmedical management, administrative support, billing systems, billing personnel, staffing, procedures, and third-party payer contracting support for Defendant Doctors Care, P.A.

36. Put differently, upon information and belief, Defendant Doctors Care, P.A. provides urgent care physicians and the UCI Defendants handle all other aspects of Defendant Doctors Care, P.A.'s administration, billing, and staffing.

37. Upon information and belief, at all times relevant to the Complaint, Defendant Doctors Care, P.A. was a participating provider in Federal Healthcare Programs.

IV. LAW, REGULATIONS, AND GUIDANCE

38. Relators re-allege and incorporate the allegations of the paragraphs above as if fully set forth herein.

A. THE FALSE CLAIMS ACT

39. The FCA provides for the award of treble damages and civil penalties for, *inter alia*, knowingly causing the submission of false or fraudulent claims for payment to the United States government. 31 U.S.C. § 3729(a)(1).

40. The FCA provides, in pertinent part, that a person who:

> (a)(1)(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
>
> (a)(1)(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
>
> (a)(1)(C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G); . . .
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the

> Federal Civil Penalties Inflation Adjustment Act of 1990[1] (28 U.S.C. 2461 note; Public Law 104-410), plus 3 times the amount of damages which the Government sustains because of the act of that person.

31 U.S.C. § 3729.

For purposes of the False Claims Act,

> the term "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information; and require no proof of specific intent to defraud.

32 U.S.C. § 3729(b)(1). Moreover, the term "material" "means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4).

B. THE MEDICARE PROGRAM

Background

41. In 1965, Congress enacted Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.*, known as the Medicare Program. Entitlement to Medicare is based on age (65 or older), disability, or affliction with end-stage renal disease. 42 U.S.C. §§ 426, 426-1.

42. Medicare is comprised of Parts A, B, C, and D. Part B is medical insurance that authorizes payment of federal funds for health services, including physician, laboratory, outpatient, diagnostic, and radiology services. *See* 42 U.S.C. § 1395k; 42 C.F.R. § 410.10.

43. The Secretary of HHS has overall responsibility for the administration of Medicare. Within HHS, the responsibility for the administration of Medicare has been delegated to the

[1] By virtue of 28 C.F.R. § 85.3(a)(9), the penalty range has increased to a minimum of $5,500 and a maximum of $11,000 per violation. For violations occurring after November 2, 2015, the civil penalty range has been further increased to a minimum of $11,000 and a maximum of $21,563 per violation. 28 C.F.R. § 85.5.

Centers for Medicare & Medicaid Services ("CMS").

44. To assist in the administration of Medicare Part B, CMS initially contracted with "carriers" or "fiscal intermediaries." Carriers, typically private insurance companies, were largely responsible for processing and paying Part B claims. 42 C.F.R. §§ 421.1–421.3.

45. Beginning in November 2006, Medicare Administrative Contractors ("MACs") began replacing carriers and fiscal intermediaries. *See* 42 U.S.C. § 1395kk-1; 42 C.F.R. § 421.400 *et seq.*; 71 F.R. 67960-01, at 68181 (Nov. 24, 2006). MACs generally act on behalf of CMS to process and pay Part B claims and perform administrative functions on a regional level.

46. Since at least 2006, Palmetto GBA served as the Medicare carrier and fiscal intermediary until May 2010, when Palmetto GBA was awarded a contract to serve as South Carolina's MAC.

47. Medicare only covers medically necessary items or services, excluding from coverage "any expenses incurred for items or services […] which […] are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." 42 U.S.C. § 1395y(a)(1)(A).

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

49. As Medicare providers, Defendants were obligated to understand and certify their compliance with all applicable Medicare laws, regulations, and program instructions as a condition of participation in Part B and as a condition of payment of Medicare reimbursements.

50. Healthcare providers are prohibited from knowingly presenting or causing to be presented claims that represent a pattern of items or services that the person knew or should have

known were not medically necessary, or knew or should have known were false or fraudulent. 42 U.S.C. §§ 1320a-7a(a)(1); 1320a-7(b)(7) (permitting exclusion of providers for the foregoing violations).

Credentialing

51. Physicians, non-physician practitioners, and other Part B providers/suppliers must enroll in the Medicare Program in order to be paid for covered services that they provide to Medicare beneficiaries.

52. In order to enroll in the Medicare Program, providers must obtain a National Provider Identifier ("NPI") number, complete a Medicare enrollment application, and await the application to be processed.

53. Upon information and belief, the enrollment and credentialing process can often be costly in terms of time, resources, and administrative overhead.

54. The enrollment and credentialing process is designed to protect Medicare beneficiaries from receiving care or services from unqualified providers, protect Medicare beneficiaries from providers whose licenses are limited or restricted, and protect Medicare beneficiaries from providers who are excluded from the Medicare program and other Federal Healthcare Programs.

55. Until a provider is enrolled and credentialed, the provider cannot bill Medicare for services provided to Medicare beneficiaries.

Claim Submission

56. Providers submit claims to Medicare on the HCFA 1500 claims form ("Form 1500"). The Form 1500 requires the provider to, *inter alia*, detail patient information, insurance information, date of treatment, provider information, and other relevant information to the patient's treatment and claim.

57. The back of the Form 1500 states, in bold print, **"Notice: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties."**

58. Critically, the Form 1500 requires the signature of the physician or provider of the medical or surgical services. By signing the Form 1500, the provider "certif[ies] that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations."

59. "For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills." *See* Form 1500.

60. According to CMS guidelines, "[t]o qualify as 'incident to,' services must be part of [a] patient's normal course of treatment during which a physician **personally performed an initial service** and remains **actively involved** in the course of treatment. [The physician] do[es] not have to physically present in the patient's treatment room while these services are provided, but [the physician] must provide **direct supervision**, that is, [the physician] must be present in the office suite to render assistance, if necessary. The patient record should document the essen-

tial requirements for incident to service."[2]

61. Thus, the presence of the billing physician in the office of a midlevel is an essential element of "incident to" billing if a claim is to be submitted under the billing physician's NPI number. This "direct supervision" requirement is necessary for patient safety.

62. When a midlevel bills for "incident to" services, the claim is paid at the higher, physician rate. Conversely, when a Physician Assistant bills Medicare directly under his or her own provider number, he or she is paid 85 percent of the fee schedule amount that a physician would receive for the same services. Therefore, improper "incident to" billing results in a provider receiving a 15 percent higher reimbursement.

63. Moreover, only management of established problems on established patients by midlevels may qualify as incident-to services. Given the nature of the urgent care services in this case, upon information and belief, all of the patient examples alleged herein involved either new patients or new problems on existing patients. Put differently, the initial care of the patient examples alleged in this complaint was not provided by a physician who writes orders for ongoing care.

64. Because it is not feasible for Medicare personnel to review every patient's medical records for the millions of claims for payments they receive from providers, the program relies on providers to comply with Medicare requirements and trusts providers to submit truthful and accurate certifications and claims.

65. Generally, once a provider submits a claim to Medicare, the claim is paid directly to the provider without any review of supporting documentation, including medical records.

[2] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf.

C. Medicaid

Background

66. Medicaid is a joint federal and state program that was created in 1965 so that states could receive federal financial assistance if they chose to reimburse certain medical costs for needy individuals.

67. States are not required to participate in the Medicaid program, but if they choose to, they must abide by the Medicaid requirements.

68. In order to be eligible for federal assistance under the Medicaid program, a state must have a plan for medical assistance that has been approved by the Secretary of HHS. 42 U.S.C. § 1396a(a).

69. When the Secretary of HHS approves a state's plan, the state then administers the various medical assistance programs under the Medicaid umbrella and the federal government provides grants to the state to reimburse them for medical services provided. *Id.*

70. The South Carolina Medicaid program provides medical services that are medically necessary for eligible beneficiaries unless limitations are noted with the policy restrictions of the relevant Provider Manual. *See Physicians, Laboratories, and Other Medical Professionals Provider Manual*, SOUTH CAROLINA HEALTHY CONNECTIONS MEDICAID at 2-1 (February 1, 2005 Edition, Last Updated November 1, 2016), *available at* https://www.scdhhs.gov/provider-type/physicians-laboratories-and-other-medical-professionals-provider-manual-020105-edition.

Credentialing

71. Physicians, non-physician practitioners, and other Medicaid providers/suppliers must enroll in the Medicaid Program in order to be paid for covered services that they provide to Medicaid beneficiaries.

72. In order to enroll in the Medicaid Program, providers must obtain a Medicaid provider identification number, complete a Medicaid enrollment application, and await the application to be processed.

73. Upon information and belief, the enrollment and credentialing process can often be costly in terms of time, resources, and administrative overhead.

74. The enrollment and credentialing process is designed to protect Medicaid beneficiaries from receiving care or services from unqualified providers, protect Medicaid beneficiaries from providers whose licenses are limited or restricted, and protect Medicaid beneficiaries from providers who are excluded from the Medicaid program and other Federal Healthcare Programs.

75. Until a provider is enrolled and credentialed, the provider cannot bill Medicaid for services provided to Medicaid beneficiaries.

Claim Submission

76. Providers submit claims to Medicare on the HCFA 1500 claims form ("Form 1500"). The Form 1500 requires the provider to, *inter alia*, detail patient information, insurance information, date of treatment, provider information, and other relevant information to the patient's treatment and claim.

77. The back of the Form 1500 states, in bold print, **"Notice: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties."**

78. Critically, the Form 1500 requires the signature of the physician or provider of the medical or surgical services. By signing the Form 1500, the provider "certif[ies] that the services listed above were medically indicated and necessary to the health of this patient and were per-

sonally furnished by me or my employee under my personal direction."

79. Services provided by a Physician Assistant or Nurse Practitioner are reimbursed at 80% of the physician rate.

80. Medicaid regulations also permit "incident to" billing in circumstances where a physician establishes a visit with a patient and a midlevel continues the treatment for related conditions pursuant to the physician's order.

81. Upon information and belief, as with Medicare and TRICARE, in order for a mid-level to bill "incident to" a physician, the services must be furnished under a physician's direct supervision, which means that the supervising physician "is accessible when the services being billed are provided." *See* Medicaid Provider Manual.

D. The TRICARE Program

Background

82. TRICARE (formerly CHAMPUS) is a triple option benefit plan established by Congress and funded through federal appropriations and allocated as part of the National Defense Authorizations Act. TRICARE was established by statute, 10 U.S.C. §§ 1071–1110, and provides health care benefits to eligible beneficiaries, which include, among others, active duty service members, retired service members, and their dependents.

83. TRICARE coverage is divided into three geographical regions, and South Carolina is in the South Region.

84. Humana Military has been awarded the contract to administer the TRICARE program for the South Region.

85. TRICARE, like Medicare, does not pay for "services[s] or suppl[ies] which [are] not medically or psychologically necessary to prevent, diagnose, or treat a mental or physical

illness, injury, or bodily malfunction as assessed or diagnosed by a physician . . . ." 10 U.S.C. § 1079(a)(12).

Credentialing

86. TRICARE only reimburses appropriate covered services for eligible beneficiaries provided by TRICARE-authorized providers.

87. Every provider must submit certification forms to TRICARE to become authorized.

88. A TRICARE-authorized provider must also complete the credentialing process and sign a contract with Humana Military.

89. In order to be get credentialed, the provider must provide verification of their education/training, board certification, license, professional and criminal background, malpractice history, and other pertinent data.

Claim Submission

90. Providers submit claims to TRICARE on the HCFA 1500 claims form ("Form 1500"). The Form 1500 requires the provider to, *inter alia*, detail patient information, insurance information, date of treatment, provider information, and other relevant information to the patient's treatment and claim.

91. The back of the Form 1500 states, in bold print, **"Notice: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties."**

92. Critically, the Form 1500 requires the signature of the physician or provider of the medical or surgical services. By signing the Form 1500, the provider "certif[ies] that the services

shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations."

93. "For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills." *See* Form 1500. Moreover, upon information and belief, the initial visit must be performed by a physician.

94. As detailed below, the services provided by midlevels did not comply with this "incident to" certification and the applicable TRICARE laws, regulations, and rules.

V. FACTUAL ALLEGATIONS REGARDING DEFENDANTS' FALSE CLAIMS

95. The UCI Defendants have a unique relationship with Defendant Doctors Care, P.A. in that the UCI Defendants provide all management, administrative, and billing services for Defendant Doctors Care, P.A. while Defendant Doctors Care, P.A. provides physician and midlevel staffing for urgent care visits.

96. Relator Rathbun is employed by the UCI Defendants and handles credentialing of Defendant Doctors Care, P.A.'s midlevels and physicians and negotiating contracts with Federal Healthcare Programs.

97. The UCI Defendants have not credentialed all of Defendant Doctors Care, P.A.'s midlevels and physicians. Upon information and belief, the UCI Defendants want to avoid the time and expense of completing the credentialing process.

98. Upon information and belief, some of the providers that Defendants failed to have credentialed may not have been eligible to be credentialed by various Federal Healthcare Programs.

99. As a result, many of Defendant Doctors Care, P.A.'s midlevels and physicians are not able to bill for services provided to patients insured by Federal Healthcare Programs.

100. In order to circumvent this problem, the UCI Defendants have directed their personnel to "link" providers together. "Linking" involves billing the services of a noncredentialed physician or midlevel under the provider signature of a credentialed physician or midlevel who took no part in the patient's treatment.

101. To accomplish this, the UCI Defendants disseminate a "cheat sheet" that shows which midlevels and physicians are credentialed by Federal Healthcare Programs so that their billing staff can "link" claims for noncredentialed midlevels and physicians.

102. In fact, the UCI Defendants maintain a running list of midlevels and physicians who have been "linked" in order to keep track of midlevel and physician claims and reimbursements.

103. Relator Dove and Relator Rathbun have both been directed by the UCI Defendants to conceal this "linking" from third-party payers, including Federal Healthcare Programs.

104. To that end, the UCI Defendants sometimes attempt to submit "corrected claims" or alter their records to conceal the improper billing from various Federal Healthcare Programs.

105. Moreover, the UCI Defendants consistently bill midlevel services as "incident to" physician services despite the fact that there is no physician on site with the midlevel or that the physician that is on site is not the physician that signs the Form 1500.

106. Additionally, the UCI Defendants consistently bill new patient claims provided by

midlevels under a physician's signature and certification in violation of "incident to" billing guidelines.

107. Upon information and belief, Defendant Doctors Care, P.A. had knowledge of the above actions or acted in deliberate ignorance or reckless disregard of the truth or falsity of the claims and/or statements made to Federal Healthcare Programs.

108. Upon information and belief, the claims in question are submitted by Defendant Doctors Care, P.A. with the assistance of billing employees that work for the UCI Defendants.

VI. WRONGFUL ACTS BY DEFENDANTS

109. The relevant time frame for the Defendants' false representations, false statements, false certifications, and false and fraudulent claims to the Federal Healthcare Programs was from at least as early as 2015 and continues to present. Upon information and belief, many of these frauds occurred prior to 2015.

110. The misrepresentations and omissions of material facts discussed herein were material to the Federal Healthcare Programs' decisions to pay the submitted claims. These misrepresentations and omissions of material facts were contained in express and/or implied representations or certifications in their claims for payment, through Form 1500s or the electronic equivalent, and include, but are not limited to, the following:

a. Defendants falsely represented or certified to the Federal Healthcare Programs that all of the Defendants' claims for payment were true, when they were not.

b. Defendants falsely represented or certified to the Federal Healthcare Programs that all of the Defendants' claims for payment were accurate, when they were not.

c. Defendants falsely represented or certified to the Federal Healthcare Programs that all of the Defendants' claims for payment were in compliance with the Federal

Healthcare Programs' laws, regulations, and rules, when they were not.

d. Defendants conspired to make false and fraudulent claims and/or statements to Federal Healthcare Programs for payment of claims.

111. As a result of the Defendants' intentionally fraudulent conduct, set forth herein, Defendants were able to unlawfully obtain funds from the Federal Healthcare Programs in violation of the FCA and the laws, regulations, and rules pertaining to Federal Healthcare Programs.

VII. EXAMPLES OF DEFENDANTS' FALSE CLAIMS

a. "Incident To" Billing for Established Patients

112. Unless indicated otherwise, the claims submitted for each of the patients below included Current Procedural Terminology ("CPT") Code 99214, which is a Level 4 Established Patient Office Visit. For some patients, other services were billed, including lab services or modifiers on the 99214 code.

113. As detailed above, while "incident to" billing for midlevel services for an established services for an established patient can be appropriate, the billing must be for an existing condition and must otherwise meet "incident to" guidelines.

114. Upon information and belief, Defendants also submitted "incident to" claims for new patients to Federal Healthcare Programs for treatment that was provided by a midlevel and submitted/certified by a physician. Upon information and belief, the claim for the initial patient visit and all subsequent "incident to" claims for treatment by a midlevel, violate the FCA because a physician did not perform the initial visit for the new patient and did not remain actively involved in the course of treatment.

115. Upon information and belief, the claims below also do not meet the "incident to" guidelines, as they involve new conditions and not routine monitoring/treatment pursuant to a

physician order and plan of care, and the certifying physician was not on site when the midlevel services were provided. Moreover, upon information and belief, many, if not all, of the midlevels listed below were not credentialed under the respective Federal Healthcare Program they billed under.

116. The following are merely example claims that, upon information and belief, are illustrative of Defendants' scheme.

1. "Incident To" Billing for Established Patients – Medicare

117. On October 1, 2016, Jane Doe 1 was treated by Nurse Practitioner Joanne Keefe-Tomasello at Doctors Care – Moncks Corner. Upon information and belief, no physician was on site at Doctors Care – Moncks Corner on October 1, 2016. Despite the lack of an on-site physician, Defendants submitted a claim to Medicare and certified that Dr. Curtis Franke was Jane Doe 1's physician-provider. Medicare processed the claim and remitted $96.46 to Defendants, including payment for the 99214 code.

118. On November 21, 2016, John Doe 1 was treated by Nurse Practitioner Judith Heintz at Doctors Care – Little River. Upon information and belief, no physician was on site at Doctors Care – Little River on November 21, 2016. Despite the lack of an on-site physician, Defendants submitted a claim to Medicare and certified that Dr. Richard Joslin was John Doe 1's physician-provider. Medicare processed the claim and remitted $80.46 to Defendants, including payment for the 99214 code.

119. On November 21, 2016, Jane Doe 2 was treated by Physician Assistant Janel Sabb at Doctors Care – Forest Acres. Upon information and belief, no physician was on site at Doctors Care – Forest Acres on November 21, 2016. Despite the lack of an on-site physician, Defendants submitted a claim to Medicare and certified that Dr. Janel Sabb was Jane Doe 2's

physician-provider. Medicare processed the claim and remitted $124.56 to Defendants, including payment for the 99214 code.

120. On December 7, 2016, Jane Doe 3 was treated by Physician Assistant Frederick Parker at Doctors Care – Northeast. Upon information and belief, no physician was on site at Doctors Care – Northeast on December 7, 2016. Despite the lack of an on-site physician, Defendants submitted a claim to Medicare and certified that Dr. Amit Pitalia was Jane Doe 3's physician-provider. Medicare processed the claim and remitted $19.60 to Defendants, including payment for the 99214 code.

121. On June 1, 2017, Jane Doe 4 was treated by Nurse Practitioner Nicole Scaccia at Doctors Care – Rock Hill. Upon information and belief, no physician was on site at Doctors Care – Rock Hill on June 1, 2017. Despite the lack of an on-site physician, Defendants submitted a claim to Medicare and certified that Dr. Erin Reilly was Jane Doe 4's physician-provider. Medicare processed the claim and remitted $83.58 to Defendants, including payment for the 99214 code.

122. On July 27, 2017, Jane Doe 5 was treated by Nurse Practitioner Heather Campbell at Doctors Care – Conway. Upon information and belief, Dr. Richard Eaton was the only physician on site at Doctors Care – Conway on July 27, 2017. Upon information and belief, Dr. Richard Eaton was not credentialed by Medicare. Despite this, Defendants submitted a claim to Medicare and certified that Dr. Artur Wilkoszewski was Jane Doe 5's physician-provider. Medicare processed the claim and remitted $80.68 to Defendants, including payment for the 99214 code.

123. These claims were false and fraudulent, and the false statements, implied certifications, and express certifications were material to the Federal Healthcare Programs' decision to pay the claims.

2. "Incident To" Billing for Established Patients – Medicaid

124. On April 13, 2017, John Doe 2 was treated by Physician Assistant Tara Sabatinos at Doctors Care – Berea. Upon information and belief, no physician was on site at Doctors Care – Berea on April 13, 2017. Despite the lack of an on-site physician, Defendants submitted a claim to Medicaid and certified that Dr. Chad Leep was John Doe 2's physician-provider. Medicaid processed the claim and remitted $102.66 to Defendants, including payment for the 99214 code.

125. On June 10, 2017, Jane Doe 6 was treated by Physician Assistant Richard Offenback at Doctors Care – Conway. Upon information and belief, Dr. Richard Eaton was the only physician on site at Doctors Care – Conway on June 10, 2017. Upon information and belief, Dr. Richard Eaton was not credentialed by Medicaid. Despite this, Defendants submitted a claim to Medicaid and certified that Dr. Artur Wilkoszewski was Jane Doe 6's physician-provider. Medicaid processed the claim and remitted $117.22 to Defendants, including payment for the 99214 code.

126. These claims were false and fraudulent, and the false statements, implied certifications, and express certifications were material to the Federal Healthcare Programs' decision to pay the claims.

3. "Incident To" Billing for Established Patients – TRICARE

127. On October 16, 2016, Jane Doe 7 was treated by Physician Assistant Kristina Shinabery at Doctors Care – Strand. Upon information and belief, no physician was on site at Doctors Care – Strand on October 16, 2016. Despite the lack of an on-site physician, Defendants submitted a claim to TRICARE and certified that Dr. Dennis Rhoades was Jane Doe 7's physician-provider. TRICARE processed the claim and remitted $142.02 to Defendants, including

payment for the 99214 code.

128. On February 13, 2017, Jane Doe 8 was treated by Nurse Practitioner Judith Heintz at Doctors Care – N. Myrtle Beach. Upon information and belief, no physician was on site at Doctors Care – N. Myrtle Beach on February 13, 2017. Despite the lack of an on-site physician, Defendants submitted a claim to TRICARE and certified that Dr. Michael Nirenstein was Jane Doe 8's physician-provider. TRICARE processed the claim and remitted $87.22 to Defendants, including payment for the 99214 code.

129. On April 13, 2017, Jane Doe 9 was treated by Physician Assistant Kristina Shinabery at Doctors Care – Strand. Upon information and belief, no physician was on site at Doctors Care – Strand on April 13, 2017. Despite the lack of an on-site physician, Defendants submitted a claim to TRICARE and certified that Dr. Dennis Rhoades was Jane Doe 9's physician-provider. TRICARE processed the claim and remitted $85.76 to Defendants, including payment for the 99214 code.

130. On May 4, 2017, Jane Doe 10 was treated by Physician Assistant Kristina Shinabery at Doctors Care – Strand. Upon information and belief, no physician was on site at Doctors Care – Strand on May 4, 2017. Despite the lack of an on-site physician, Defendants submitted a claim to TRICARE and certified that Dr. Dennis Rhoades was Jane Doe 10's physician-provider. TRICARE processed the claim and remitted $30 to Defendants, including payment for the 99214 code.

131. On May 29, 2017, Jane Doe 11 was treated by Nurse Practitioner Leia Oberg at Doctors Care – Mount Pleasant. Upon information and belief, Dr. Susan Cao was the only physician on site at Doctors Care – Mount Pleasant on May 29, 2017. Upon information and belief, Dr. Susan Cao was not credentialed by TRICARE. Despite this, Defendants submitted a claim to

TRICARE and certified that Dr. John Ward was Jane Doe 11's physician-provider. TRICARE processed the claim and remitted $107.91 to Defendants, including payment for the 99214 code.

132. On June 16, 2017, Jane Doe 12 was treated by Physician Assistant William Finch at Doctors Care – Summerville. Upon information and belief, no physician was on site at Doctors Care – Summerville on June 16, 2017. Despite the lack of an on-site physician, Defendants submitted a claim to TRICARE and certified that Dr. Joe Marino was Jane Doe 12's physician-provider. TRICARE processed the claim and remitted $100.47 to Defendants, including payment for the 99214 code.

133. On July 29, 2017, Jane Doe 13 was treated by Nurse Practitioner Kim Ford at Doctors Care – Surfside. Upon information and belief, there was no physician on site at Doctors Care – Surfside on July 29, 2017. Despite the lack of an on-site physician, Defendants submitted a claim to TRICARE and certified that Dr. Thomas Gibbons was Jane Doe 13's physician-provider. TRICARE processed the claim and remitted $97.99 to Defendants, including payment for the 99214 code.

134. On July 30, 2017, Jane Doe 14 was treated by Nurse Practitioner Tonia Locke at Doctors Care – Greenwood. Upon information and belief, there was no physician on site at Doctors Care – Greenwood on July 30, 2017. Despite the lack of an on-site physician, Defendants submitted a claim to TRICARE and certified that Dr. Lynda McKinnon was Jane Doe 14's physician-provider. TRICARE processed the claim and remitted $83.10 to Defendants, including payment for the 99214 code.

135. On August 14, 2017, Jane Doe 15 was treated by Nurse Practitioner Mary Tabatha Simon at Doctors Care – Berea. Upon information and belief, there was no physician on site at Doctors Care – Berea on August 14, 2017. Despite the lack of an on-site physician, De-

fendants submitted a claim to TRICARE and certified that Dr. Chad Leep was Jane Doe 15's physician-provider. TRICARE processed the claim and remitted $89.71 to Defendants, including payment for the 99214 code.

136. These claims were false and fraudulent, and the false statements, implied certifications, and express certifications were material to the Federal Healthcare Programs' decision to pay the claims.

4. "Incident To" Billing for Established Patients – Select Health – Medicaid Managed Care Organization

137. On December 20, 2016, Jane Doe 16 was treated by Physician Assistant Catherine Tumbleson at Doctors Care – Conway. Upon information and belief, there was no physician on site at Doctors Care – Conway on December 20, 2016. Despite the lack of an on-site physician, Defendants submitted a claim to Select Health and certified that Dr. Artur Wilkoszewski was Jane Doe 16's physician-provider. Select Health processed the claim and remitted $84.55 to Defendants, including payment for the 99214 code.

138. On February 1, 2017, Jane Doe 17 was treated by Physician Claire Kirkpatrick at Doctors Care – Mt. Pleasant. Upon information and belief, Dr. Susan Cao was the only physician on site at Doctors Care – Mt. Pleasant on February 1, 2017. Upon information and belief, Dr. Susan Cao was not credentialed by Select Health. Despite this, Defendants submitted a claim to Select Health and certified that Dr. Curtis Franke was Jane Doe 17's physician-provider. Select Health processed the claim and remitted $75.50 to Defendants, including payment for the 99214 code.

139. On May 18, 2017, John Doe 3 was treated by Nurse Practitioner Tonia Locke at Doctors Care – Greenwood. Upon information and belief, Dr. Robert Sylvester was the only physician on site at Doctors Care – Greenwood on May 18, 2017. Upon information and belief,

Dr. Robert Sylvester was not credentialed by Select Health. Despite this, Defendants submitted a claim to Select Health and certified that Dr. Elvira Baker was John Doe 3's physician-provider. Select Health processed the claim and remitted $74.54 to Defendants, including payment for the 99214 code.

140. On May 30, 2017, John Doe 4 was treated by Physician Assistant Carly Schneider at Doctors Care – Berea. Upon information and belief, there was no physician on site at Doctors Care – Berea on May 30, 2017. Despite the lack of an on-site physician, Defendants submitted a claim to Select Health and certified that Dr. Chad Leep was John Doe 4's physician-provider. Select Health processed the claim and remitted $103.29 to Defendants, including payment for the 99214 code.

141. On June 28, 2017, Jane Doe 18 was treated by Physician Assistant Robin Shaver at Doctors Care – Strand. Upon information and belief, Dr. Robert Frank was the only physician on site at Doctors Care – Strand on June 28, 2017. Upon information and belief, Dr. Robert Frank was not credentialed by Select Health. Despite this, Defendants submitted a claim to Select Health and certified that Dr. Dennis Rhoades was Jane Doe 18's physician-provider. Select Health processed the claim and remitted $118.86 to Defendants, including payment for the 99214 code.

142. These claims were false and fraudulent, and the false statements, implied certifications, and express certifications were material to the Federal Healthcare Programs' decision to pay the claims.

5. "Incident To" Billing for Established Patients – Dual Federal Payors

143. On March 11, 2017, Jane Doe 19 was treated by Physician Assistant Daniela Harmon at Doctors Care – Anderson. Upon information and belief, there was no physician on

site at Doctors Care – Anderson on March 11, 2017. Despite the lack of an on-site physician, Defendants submitted claims to Medicare and Medicaid and certified that Dr. Lynda McKinnon was Jane Doe 19's physician-provider. Medicare processed the claim and remitted $80.68 to Defendants, and Medicaid processed the claim and remitted $17.28 to Defendants, including payment for the 99214 code.

144. On March 29, 2017, John Doe 5 was treated by Physician Assistant Leland George at Doctors Care – Forest Acres. Upon information and belief, Dr. Alfred Frye was the only physician on site at Doctors Care – Forest Acres on March 29, 2017. Upon information and belief, Dr. Alfred Frye was not credentialed by Medicare and/or Medicaid. Despite this, Defendants submitted claims to Medicare and Medicaid and certified that Dr. Erin Reilly was John Doe 5's physician-provider. Medicare processed the claim and remitted $84.92 to Defendants, and Medicaid processed the claim and remitted $17.28 to Defendants, including payment for the 99214 code.

145. On July 13, 2017, Jane Doe 20 was treated by Nurse Practitioner Jo Hammett at Doctors Care – Greenwood. Upon information and belief, Dr. Robert Sylvester was the only physician on site at Doctors Care – Greenwood on July 13, 2017. Upon information and belief, Dr. Robert Sylvester was not credentialed by Medicare and/or Medicaid. Despite this, Defendants submitted claims to Medicare and Medicaid and certified that Dr. Lynda McKinnon was Jane Doe 20's physician-provider. Medicare processed the claim and remitted $80.68 to Defendants, and Medicaid processed the claim and remitted $17.28 to Defendants, including payment for the 99214 code.

146. On July 25, 2017, John Doe 6 was treated by Nurse Practitioner Nicole Scaccia at Doctors Care – Indian Land. Upon information and belief, there was no physician on site at Doc-

tors Care – Indian Land on July 25, 2017. Despite the lack of an on-site physician, Defendants submitted claims to Medicare and TRICARE and certified that Dr. Erin Reilly was John Doe 6's physician-provider. The office visit claims were submitted under CPT code 99213 rather than 99214. Medicare processed the claim and remitted $54.71 to Defendants, and TRICARE processed the claim and remitted $13.96 to Defendants, including payment for the 99213 code.

147. These claims were false and fraudulent, and the false statements, implied certifications, and express certifications were material to the Federal Healthcare Programs' decision to pay the claims.

b. Billing for MDs That Did Not Provide Treatment

148. On April 1, 2017, Jane Doe 21 was treated by Dr. Richard Eaton at Doctors Care – Conway. Yet, Defendants submitted a claim to Medicare and certified that Dr. Artur Wilkoszewski was Jane Doe 21's physician-provider. Medicare processed the claim and remitted $101.67 to Defendants, including payment for the 99214 code. Upon information and belief, Dr. Richard Eaton was not credentialed by Medicare when the treatment was provided.

149. On April 3, 2017, Jane Doe 22 was treated by Dr. Alice Savage at Doctors Care – Northwoods. Yet, Defendants submitted a claim to Medicare and certified that Dr. Curtis Franke was Jane Doe 22's physician-provider. Medicare processed the claim and remitted $195.08 to Defendants, including payment for the 99214 code. Upon information and belief, Dr. Alice Savage was not credentialed by Medicare when the treatment was provided.

150. On May 13, 2017, Jane Doe 23 was treated by Dr. Herold Nazon at Doctors Care – Orangeburg. Yet, Defendants submitted a claim to Medicare and certified that Dr. Alan Jolles was Jane Doe 23's physician-provider. Medicare processed the claim and remitted $80.68 to Defendants, including payment for the 99214 code. Upon information and belief, Dr. Herold Nazon

was not credentialed by Medicare when the treatment was provided.

151. On July 30, 2017, Jane Doe 24 was treated by Dr. Michael Varney at Doctors Care – Little River. Yet, Defendants submitted a claim to Medicare and certified that Dr. Richard Joslin was Jane Doe 24's physician-provider. Medicare processed the claim and remitted $81.28 to Defendants, including payment for the 99214 code. Upon information and belief, Dr. Michael Varney was not credentialed by Medicare when the treatment was provided.

152. These claims were false and fraudulent, and the false statements, implied certifications, and express certifications were material to the Federal Healthcare Programs' decision to pay the claims.

c. "Incident To" Billing for New Patients

153. The examples of improper "incident to" billing listed above generally involved established patient visits. However, Defendants also violated "incident to" billing guidelines when performing new patient visits.

154. When a provider sees a new patient, the office visit is generally billed under CPT Codes 99201–99205.

155. As detailed above, the Federal Healthcare Programs require the initial patient visit to be performed by a physician in order for later visits to be billed as "incident to."

156. Thus, a midlevel cannot perform a patient's initial visit and bill the services under a physician's signature and certification.

157. The following are examples of claims where a new patient visit was performed by a midlevel and the claim was billed under a physician's signature and certification.

158. Claims of this type, and any subsequent "incident to" services provided to those patients were false and fraudulent because the initial visit was not performed by a physician.

159. On January 8, 2016, Jane Doe 25 was treated by Physician Assistant Jordan Crosby at Doctors Care – Berea. Upon information and belief, Jane Doe 25 was a new patient. Defendants submitted a claim to Medicaid and BlueChoice HealthPlan Medicaid for CPT Code 99203 and certified that Dr. Chad Leep was Jane Doe 25's physician-provider. However, upon information and belief, Dr. Leep was not working at Doctors Care – Berea on January 8, 2016, and in fact there was no physician on site. Therefore, upon information and belief, Dr. Leep did not provide any treatment for Jane Doe 25 at this visit. Medicaid did not pay anything for this claim. However, BlueChoice HealthPlan processed the claim and remitted $102.41 to Defendants, including payment for the 99203 code.

160. On June 27, 2017, John Doe 7 was treated by Physician Assistant Gwendolyn Strickland at Doctors Care – Conway. Upon information and belief, John Doe 7 was a new patient. Defendants submitted a claim to Medicare for, *inter alia*, CPT Code 99204 and certified that Dr. Artur Wilkoszewski was John Doe 7's physician-provider. However, upon information and belief, the only physician on site at Doctors Care – Conway on June 27, 2017 was Dr. Dennis Rhoades, who, upon information and belief, was not credentialed by Medicare at the time. Therefore, upon information and belief, Dr. Wilkoszewski did not provide any treatment for John Doe 7 at this visit. Medicare processed the claim and remitted $139.22 to Defendants, including payment for the 99204 code.

161. On July 20, 2017, John Doe 8 was treated by Physician Assistant Carita McWilliams at Doctors Care – Orangeburg. Upon information and belief, John Doe 8 was a new patient. Defendants submitted a claim to TRICARE for, *inter alia*, CPT Code 99203 and certified that Dr. Alan Jolles was John Doe 8's physician-provider. However, upon information and belief, while Dr. Jolles was on site at Doctors Care – Orangeburg on July 20, 2017, he did not

provide any treatment for John Doe 8 at this visit. TRICARE processed the claim and remitted $155.49 to Defendants, including payment for the 99203 code.

162. On March 18, 2016, John Doe 9 was treated by Physician Assistant Jordan Crosby at Doctors Care – Berea. Upon information and belief, John Doe 9 was a new patient. Defendants submitted a claim to Medicaid for, *inter alia*, CPT Code 99203 and certified that Dr. Chad Leep was John Doe 9's physician-provider. However, upon information and belief, Dr. Leep was not working at Doctors Care – Berea on March 18, 2016, and in fact there was no physician on site. Therefore, upon information and belief, Dr. Leep did not provide any treatment to John Doe 9 at this visit. Medicaid processed the claim and remitted $104.43 to Defendants, including payment for the 99203 code.

163. These claims were false and fraudulent, and the false statements, implied certifications, and express certifications were material to the Federal Healthcare Programs' decision to pay the claims.

d. Improper Billing for Crutches

164. Upon information and belief, Defendants billed Medicaid for wooden crutches under HCPCS Code E0112 anytime a patient needed crutches.

165. However, upon information and belief, Defendants only stocked metal crutches (HCPCS Code E0114) and, thus, only provided patients with metal crutches, which were not covered by Medicaid.

166. For example, on January 12, 2016, Jane Doe 26 was treated by Dr. Robert Hetz at Doctors Care – Moncks Corner for right ankle and leg pain. Upon information and belief, Dr. Hetz prescribed metal crutches and provided Jane Doe 26 with metal crutches. However, Defendants billed Medicaid and certified that Jane Doe 26 received wooden crutches. Medicaid

processed the claim and remitted $175.30 to Defendants, which included payment of $23.36 for the E0112 code that Defendants changed after Jane Doe 26's treatment.

167. On March 17, 2017, John Doe 10 was treated by Dr. Edward Allen Neilsen at Doctors Care – Ridgeview for right knee pain. Upon information and belief, Dr. Neilsen prescribed metal crutches and provided John Doe 10 with metal crutches. Defendants initially billed Medicaid under E0114, which was denied. Thereafter, Defendants billed Medicaid again, changing the code to E0112, and certified that John Doe 10 received wooden crutches. Medicaid processed the claim and remitted $23.36 to Defendants, which included payment of $23.36 for the E0112 code that Defendants changed after John Doe 10's treatment.

168. These claims were false and fraudulent, and the false statements, implied certifications, and express certifications were material to the Federal Healthcare Programs' decision to pay the claims.

e. Improper Billing for Solu-Medrol

169. Upon information and belief, Defendants billed Federal Healthcare Programs for HCPCS Code J2920—Solu-Medrol.

170. However, upon information and belief, providers were actually ordering and providing Depo-Medrol.

171. Thus, upon information and belief, Defendants were billing for services not rendered and the patient charts do not match the claims submitted.

172. For example, on January 31, 2017, Jane Doe 27 was treated by Physician Assistant Bruce Wilson at Doctors Care – North Myrtle Beach for persistent cough. Dr. Wilson ordered a 40 mg, intramuscular, shot of Depo-Medrol (methylprednisolone acetate), which, upon information and belief, was provided during the visit. The internal system used by Defendants

indicates an NDC # of 0009-3073-22, which corresponds with Depo-Medrol. However, the Med Charge is listed as J2920, which corresponds to Solu-Medrol (methylprednisolone sodium succinate). Defendants submitted a claim for, *inter alia*, J2920 to Medicare, which processed the claim and remitted $33.87 to Defendants, including $3.14 for J2920. Upon information and belief, the proper code for 40 mg, intramuscular, Depo-Medrol is J1030.

173. These claims were false and fraudulent, and the false statements, implied certifications, and express certifications were material to the Federal Healthcare Programs' decision to pay the claims.

f. Medicare Wellness Visits

174. Medicare covers an Annual Wellness Visit ("AWV"), which provides Personalized Prevention Plan Services for beneficiaries who are not within the first 12 months of their first Medicare Part B coverage period and haven't received an AWV within the last 12 months.

175. The AWV includes a Health Risk Assessment ("HRA") and requires a variety of documentation that is completed by the patient's healthcare provider.

176. There are a variety of billing codes associated with these Medicare wellness programs, including (1) G0438 and G0439, which are codes for the AWVs; (2) G0402, which is the code for the Initial Preventive Physical Exam ("IPPE"); and (3) G0403–G0405, which correspond to additional EKG services performed in conjunction with the IPPE.

177. Defendants have been billing Medicare for services provided under these codes, despite the fact that they are not fulfilling the mandatory requirements for each respective code.

178. For example, on January 10, 2017, John Doe 11 was treated by Dr. Robert Lusik at Doctors Care – Bluffton. Dr. Lusik noted that John Doe 11 was being seen for an annual examination. Upon information and belief, Dr. Lusik did not complete any of the required docu-

mentation for the IPPE. Yet, Defendants submitted a claim to Medicare for G0402 and impliedly and/or expressly certified that Dr. Lusik had completed the requisite documentation to support such a billing. Medicare processed the claim and remitted $156.81 to Defendants, including payment for G0402.

179. These claims were false and fraudulent, and the false statements, implied certifications, and express certifications were material to the Federal Healthcare Programs' decision to pay the claims.

COUNT I
Presentation of False Claims and False Statements

180. Relators re-allege and incorporate the allegations of the paragraphs above as if fully set forth herein.

181. As described above, Defendants knowingly, or in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, presented or caused to be presented, and are still presenting, or causing to be presented, false or fraudulent claims for payment or approval by Federal Healthcare Programs, in violation of, *inter alia*, 31 U.S.C. § 3729(a)(1)(A).

182. As described above, Defendants knowingly, or in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, made, used, caused to be made, or caused to be used, false records and statements that were material to the Federal Healthcare Programs' payment of Defendant's false and fraudulent claims, in violation of, *inter alia*, 31 U.S.C. § 3729(a)(1)(B).

183. As described above, Defendants conspired to defraud the government by getting false or fraudulent claims paid or allowed, in violation of, *inter alia*, 31 U.S.C. § 3729(a)(1)(C).

184. Each impermissible claim for the payment of physician services represents a false or fraudulent record or statement. Further, each such claim submitted to Federal Healthcare Pro-

grams constitutes a false or fraudulent claim for payment.

185. The United States, unaware of the falsity of the claims and/or statements, and in reliance on the accuracy thereof, paid and continues to pay for services provided to individuals insured by the Federal Healthcare Programs.

186. As a result of Defendants' fraudulent actions, the United States has been, and will continue to be, severely damaged.

COUNT II
Unjust Enrichment/Disgorgement

187. Relators re-allege and incorporate the allegations of the paragraphs above as if fully set forth herein.

188. As a result of the acts set forth in this Complaint, Defendants were unjustly enriched. The United States conferred benefits upon Defendants by paying false claims and Defendants knew of and accepted these benefits. Defendants' retention of these benefits would be unjust in light of their fraudulent conduct.

189. Relators then claim the recovery of all monies by which Defendants have been unjustly enriched, in an amount to be determined at trial, which should be paid to the United States.

WHEREFORE, Relators respectfully request this Court to enter judgment against Defendants, as follows:

a) that the United States be awarded damages in the amount of three times the damages sustained by the United States because of the false claims and fraud alleged within this Complaint, as the False Claims Act provides;

b) that civil penalties in the maximum amount allowable by law be imposed for each and every false claim that Defendants presented to the United States and/or its agencies;

c) that Defendant be ordered to disgorge all sums by which they have been enriched unjustly by their wrongful conduct;

d) that pre- and post-judgment interest be awarded, along with reasonable attorneys' fees, costs, expert fees, and expenses which the Relators necessarily incurred in bringing and pressing this case;

e) that the Court grant permanent injunctive relief to prevent any recurrence of the False Claims Act for which redress is sought in this Complaint;

f) that the Relators be awarded the maximum amount allowed to her pursuant to the False Claims Act; and

g) that this Court award such other and further relief as it deems proper.

DEMAND FOR JURY TRIAL

Relators, on behalf of themselves and the United States, demand a jury trial on all claims triable alleged herein.

(Signature Page Follows)

Respectfully Submitted,

/s/ John L. Warren III
John S. Simmons, Federal ID No. 5000
jsimmons@simmonslawfirm.com
Derek A. Shoemake, Federal ID No. 10825
dshoemake@simmonslawfirm.com
John L. Warren, Federal ID No. 12164
jwarren@simmonslawfirm.com
Simmons Law Firm, LLC
1711 Pickens Street
Columbia, SC 29201
Telephone: 803-779-4600
Facsimile: 803-254-8874

Herbert W. Louthian Jr., Federal ID No. 2729
bert@louthianlaw.com
Louthian Law Firm, PA
P.O. Box 1299
Columbia, SC 29202
Telephone: 803-454-1200

Counsel for Relator Dove

/s/ Fran Trapp
Fran Trapp, Federal ID No. 6376
fran@billnettleslaw.com
2008 Lincoln Street
Columbia, SC 29201
Telephone: 803-814-2826

Counsel for Relator Rathbun

September 18, 2017