

United States District Court

Southern

DISTRICT OF

New York

U.S. sd. rel.
Joseph Kim

SUMMONS IN A CIVIL CASE

V.

CASE NUMBER:

Medco Enterprises, Inc.

07 CV 1305

Judge Hellerstein

TO: (Name and address of defendant)

~~Medco Enterprises, Inc.~~
*Medco Enterprises, Inc.
3530 Wayne Ave.
Bronx, New York*

YOU ARE HEREBY SUMMONED and required to serve upon PLAINTIFF'S ATTORNEY (name and address)

Timothy J. McInnis
Law Office of Timothy J. McInnis
521 Fifth Avenue, Suite 1700
New York, New York 10175

an answer to the complaint which is herewith served upon you, within 20 days after service of this summons upon you, exclusive of the day of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the complaint. You must also file your answer with the Clerk of this Court within a reasonable period of time after service.

J. MICHAEL M. IAHON

CLERK

FEB 21 2007

DATE

Marcos Quintero

(BY) DEPUTY CLERK

RETURN OF SERVICE

Service of the Summons and Complaint was made by me ¹	DATE
NAME OF SERVER (PRINT)	TITLE

Check one box below to indicate appropriate method of service

- Served personally upon the defendant. Place where served: _____

- Left copies thereof at the defendant's dwelling house or usual place of abode with a person of suitable age and discretion then residing therein.
Name of person with whom the summons and complaint were left: _____

- Returned unexecuted: _____

- Other (specify): _____

STATEMENT OF SERVICE FEES

TRAVEL	SERVICES	TOTAL

DECLARATION OF SERVER

I declare under penalty of perjury under the laws of the United States of America that the foregoing information contained in the Return of Service and Statement of Service Fees is true and correct.

Executed on _____
Date

Signature of Server

Address of Server

(1) As to who may serve a summons see Rule 4 of the Federal Rules of Civil Procedure.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JOSEPH KIM,

Plaintiff,

v.

MEDCO ENTERPRISES INC.,

Defendant.

No. 07 CV 1305 (AKH)

AMENDED COMPLAINT AND DEMAND FOR JURY TRIAL

1. This is a civil action by Joseph Kim against Medco Enterprises, Inc., Kim's former employer, for damages and other relief under the whistleblower protection provisions of the federal False Claims Act, 31 U.S.C. § 3730(h). As set forth below, Medco retaliated against Kim by means of unwarranted negative performance evaluations and firing him after he complained to his supervisors about practices at the Wayne Center for Nursing and Rehabilitation which compromised the care of patients and for which Medco received Medicaid and Medicare reimbursement.

2. As alleged more specifically below, in connection with Medicaid and Medicare reimbursement for the treatment of patients at the Wayne Center for Nursing and Rehabilitation, owned and operated by Medco, Medco created false and fraudulent patient charts and records that were used as the basis for billing Medicaid and Medicare for services that were not performed, not medically necessary, and substandard. Kim investigated, reported, and provided evidence to his supervisors substantiating these fraudulent practices. In response, Medco singled out Kim for criticism and disciplinary action, harassed him, and ultimately fired him.

PARTIES, JURISDICTION, AND VENUE

3. Kim is a registered respiratory therapist (“RT”). From about April 2001 to March 2004, Kim worked for Medco Enterprises, Inc., the defendant, at the Wayne Center for Nursing and Rehabilitation (“Wayne”), 3530 Wayne Avenue, Bronx, New York.

4. Medco Enterprises, Inc. is, on information and belief, a New York for-profit corporation, and is a self-described “senior care provider.” According to its published information, Wayne is operated by Wayne Center for Nursing and Rehabilitation, 3530 Wayne Avenue, Bronx, New York (“Wayne”).

5. This court has subject matter jurisdiction over the claims alleged in this Complaint under the whistleblower protection provisions of the False Claims Act, 31 U.S.C. § 3730(h) and 28 U.S.C. § 1331 (federal question).

6. Venue is proper in this district pursuant to 31 U.S.C. §§ 3732(a) and 1391 because Medco can be found, resides, and transacts business in the Southern District of New York; an act proscribed by 31 U.S.C. § 3729 occurred within this District; and a substantial part of the events or omissions giving rise to the claims occurred in this district. Section 3732(a) further provides for nationwide service of process.

DEFENDANT'S FRAUDULENT SCHEMES

7. According to New York State Department of Health published information, Wayne is a 243-bed Medicaid- and Medicare-certified facility, and its occupancy rate in 2002-2004 ranged from 90.5% up to 93.3%.

8. Most of the patients at Wayne were Medicaid or Medicare patients. As to private-pay patients, it was common knowledge among the staff that they were to “suck them dry” financially in order to make them eligible for Medicaid.

9. According to New York State Department of Health records, Medicaid payments to Medco in 2001 through 2005 ranged from \$13.5 million to \$14.4 million annually; as of March 1, 2006, Medicaid had paid Wayne \$1.9 million.

10. For Medicaid patients on a ventilator, the Medicaid reimbursement rate is some \$600 per day, much higher than the rate for ambulatory patients. Wayne is the only Medco facility with respiratory patients. The vent unit was frequently referred to by Wayne management and staff as Medco's “crown jewel” because it was where the company made its money.

11. Patients who arrived at the facility from a hospital were accompanied with a “PRI” form containing a diagnosis, treatment information, and payment information including whether they were on Medicare or Medicaid. Kim reviewed the PRI form for the patients assigned to him as it was the basis for his performing an assessment for purposes of a treatment plan. Many if not most of the PRI forms Kim saw indicated that the patients were or Medicaid or Medicare patients.

12. Kim was also asked at times to fill out “MDS” forms, which indicated among other information the number of hours of respiratory therapy each patient received, and which were completed once a week. The director of respiratory care, Hani Jereis, instructed Kim to fill in 1800 minutes for the ventilator patients and 800 to 900 minutes for trach collar patients (including for patients other than those which he treated), while the care Kim provided averaged

approximately 560 minutes per week. Supervisors asked Kim and other RTs to complete the MDS forms because they were needed for billing, including billing the government. Kim was also asked to backdate MDS forms that were past due and had not been completed, in some instances to dates when he was not at the facility. When he refused to do so he was criticized for not being a “team player.”

Precharting

13. RTs wrote notes in patient charts before visiting the patients. In many instances the therapists, after writing the fraudulent note, did not actually see or treat the patient at all.

14. The 24-hour monitoring sheets maintained by Wayne are a prime example of precharting. Many nurses filled out these sheets 24-hour monitoring sheets for the entire night at once. It was standard practice for the monitoring nurse to prechart by writing “NAD” (“no apparent distress”) in the slot for each hour from midnight to 7:00 AM on the log sheets in advance. These entries indicate that the patients were monitored every two hours from midnight to 7:00 AM, but they were completed at about 1:30 A.M. Not only monitoring, but suctioning was also precharted without actually being done. As an example, a teenage female patient who was not properly monitored died. As a result, Wayne’s management directed that the monitoring sheets no longer be kept in the patient charts.

15. Ventilator flow sheets were also precharted and otherwise falsified. As examples the time the patient was supposedly seen was not filled contemporaneously but was added later; and other entries were left out (e.g., the charts for Room 221, September 22 and Room 217, November 2, 2003.)

16. As another example, a flow sheet, containing an entry stating that the patient was pronounced dead at 10:15 AM on March 18, 2004, was falsified with subsequent entries from 9 PM to 6 AM on the night of March 18-19, 2004, stating that the patient was “stable on vent support,” was suctioned and tolerated it well (twice), received tracheotomy (“trach”) care, and was “awake” and in “no distress.” The last entry was subsequently crossed out and marked “error.”

17. As another example, the orders for a patient, Ms. B., stated that she must be placed on the vent either at night or for at least 2 to 3 hours during the night, and for her to remain in 3S, the certified vent unit, she had to be on the vent at least 1 to three hours a day. From about October 2003 to at least April 2004, the night orders were not followed completely.

18. Kim complained about these practices to the nurses and other RTs, and to the then director of the department, Larry Padilla. Padilla issued a memo to the staff condemning the practice, but no other steps were taken by Wayne management to monitor or prevent precharting. Instead, Padilla made up numbers for the administration to show the department staff that compliance was improving.

Ghost-charting and postcharting

19. RTs, including Padilla and others, filled in ventilator flow sheets without actually having checked the patients' condition and without ever being present at all (ghost-charting).

20. Ghost-charting was especially prevalent on the night shift, when therapists were sleepy and even took 3 to 4 hour naps. As a “professional courtesy,” knowing that medications were not being given, RTs often left a blank space in the patients' chart for a note to be squeezed in, sometimes days later, falsely stating, “medication given.” As an example, the progress note

for Room 211A, December 16, 2002, 3:55 PM says vent was checked but there is no corresponding data entry. Kim gave this sheet to Anderson and Thompson. About a week later, Kim found that the data was filled in.

21. RTs failed to enter monitoring data in ventilator flowsheets. As an example, the chart for Room 210B, April 4-5, 2002, indicates that only one vent check was done per shift, and no medical treatment was given. As another example, the chart for Room 214A, June 9, 2003, 4:35 PM shows a failure to provide required trach care.

22. Because it was time-consuming to complete the ventilator flow sheets, RT records, which did not include narrative comments, were used instead. These charts were also frequently left blank, and Kim observed them being filled in a day or two later (postcharting).

Billing for other services not performed

23. Bronchodilator medication that was prescribed for patients was not administered. Ana Perez, the Respiratory Department director, and other technicians regularly left the medication in the in delivery cart but nevertheless wrote in the charts that it had been given.

24. Some of the medication was to be administered between 5:00 and 7:00 P.M. Perez, who was responsible for doing so, regularly went home at 5:00 P.M., which means that the medication could not have been given.

Furnishing services that were not medically necessary

25. Patients in "weaning mode" were to be taken off their ventilator unit for periods of time. A nurse supervisor, Regina Caluyo, nevertheless directed that patients in weaning mode be placed on the ventilator because Medicaid could not be billed unless the patients were on the

ventilator for 2 to 3 hours a day. As an example, a patient who was supposed to be weaned from the respirator was left in the vent unit, where no effort was made to wean her.

26. In another instance a patient was to be admitted to an isolation room when the patient did not require isolation. Kim notified Perez of the impending improper admission and was told to “just do your job”; “the beds must be filled!”

Furnishing substandard services

27. To cut costs, Medco’s management reduced the number of RTs. At times there were only one or two RTs for 40 or more patients.

28. RTs routinely failed to chart the patient’s vital signs. As an example, the charts for room 209B and 204A, March 30-April 1, 2003, contain blanks following “HR” and “RR” (heart rate and respiratory rate), instances of precharting that was not completed even retroactively.

29. As another example, the chart for the patient in Room 406A, January 27-30, 2003, shows that Perez made only one assessment of the patient’s condition in the first shift on January 27, 2003, when two assessments per shift were required to be done. The same narrative shows no monitoring of the patient’s vital signs on January 28.

30. Pulse-ox measurements were frequently entered even when the monitors lacked functioning batteries. When Kim complained to Padilla about this, Padilla said, “everyone knows those numbers are made up.”

31. As example, in the chart for Room 212B, February 17-22, 2004, the RT made entries for O₂ sat. and HR (oxygen saturation and heart rate) but left blanks intending that the numbers would be filled in later (which in these instances was not done).

32. As another example, the patient whose chart indicates that he was hospitalized and then returned to Wayne on May 14, 2002 was supposed to be given Flovent every 12 hours, which would normally have been at 6 AM and 6 PM, but there are no entries in the chart that confirm that this was done. In addition, there is no record that the patient's vital signs were checked. The patient died the next day.

33. RTs failed to note the time they saw the patient, failed to record all the required data, and failed to initial their entries.

34. Wayne created other fraudulent charts which indicate that a technician performed an inordinate number of tasks (e.g. changing the trach tube, performing an assessment, and giving medical treatment) within a 10-minute time period, when a trach change itself usually takes approximately 10 minutes. As examples, Perez's charts for June 10, 2003 indicate ten-minute intervals for her treating three patients on the first round; six patients on the second round; and five patients on the third round. She also made narrative entries at ten-minute intervals for three of these patients.

35. As another example, according to Padilla's notes for June 9, 2003, he performed vent and trach care on two patients within a five-minute period. Padilla's charts also indicate that both patients received trach care only once during the night shift. Later entries indicate a vent check performed in ten minutes, and no trach care on the second shift.

36. Patients were neglected for all or most of a given RT's shift. As an example, the narrative entries reveal that the patient in 213B was not seen between 8:36 PM on June 8 and 9:51 AM on June 9, 2003; although there are numerical entries for 2:34 AM on June 9, there is no corresponding narrative.

37. Another chart indicates that the patient in 205B was not monitored in over 10 hours on June 26-27, 2002. Still another indicates that a patient in 202 was not seen for 18 hours on February 8, 2002, resulting in her having to be put back on a ventilator. On February 7-9, 2002, another patient, in 207A, went for almost 12 hours without receiving care. In still other charts, the treatment notes do not match the entries in the flowsheet, or the charts otherwise indicate on their face a failure to provide required treatment. For example, the patient in 202A, February 2-15, 2002.

38. As another example, blanks in the ventilator flowsheet for the patient in Room 205B indicates that no treatment was rendered on May 14, 2002 at 9:35 PM, and on May 15 at 5:38 AM, and the narrative for the latter entry omits any mention of a vent check that should have been done.

39. Some patients in weaning mode were not placed back on ventilators when they should have been. At least one patient died as a result. Several other patients, including a teenager, died because virtually no care, including trach care and suctioning was performed.

40. On March 6, 2004, a patient, Ms. K., was going to be admitted to an isolation room when she did not have isolation requirements. This was unethical and dangerous, and before she was admitted Kim told Perez so. Perez told Kim to "just do your job" and "the beds must be filled."

41. The wrong Flovent dosage was given frequently and charted improperly. RTs arbitrarily administered either 110 or 220 mg. doses.

Creating additional false records

42. Padilla changed the Policy and Procedure handbook as to the company's stated qualifications for Department Director prior to annual state inspections.

43. Kim complained about the precharting and other fraudulent practices described above to Wayne's management, including facility administrator Wolf in about May or June 2002 and to his successor, Miriam Thompson, in about May or June 2003; and to the director and the assistant director of nursing, Norma Anderson and Kathy Dougherty. However, nothing was done to remedy the violations. Instead, the director of nursing told Kim, "if it's that bad, you should look elsewhere."

44. Kim also told Thompson that Padilla had altered the Department Director minimum qualifications before state inspections.

45. After Kim began complaining about the precharting and other fraudulent practices, he was singled out and subjected to unwarranted criticism and disciplinary action. As an example, the first disciplinary notice legitimately pointed out that Kim had made an error in charting, but other RTs who made similar errors, including Padilla and Perez, were not written up. The subsequent disciplinary notices Kim received were also for errors for which he was written up, but his coworkers were not.

46. The criticisms made against Kim for not being a "team player" were also, in reality, an expression of management's displeasure over the fact that Kim refused to cover for other employees who engaged in the fraudulent practices described in this complaint.

47. Ultimately on the basis of these criticisms, in March 2004 Medco terminated Kim's employment. As with the disciplinary notices, the reasons for the termination were a pretext on the part of Wayne punish and get rid of Kim because of his whistleblowing.

COUNT I

(Retaliation—31 U.S.C. § 3730(h))

48. Kim repeats paragraphs 1 through 47 above.

49. Kim learned of and investigated the fraudulent practices described above. Kim reported and provided evidence substantiating these fraudulent practices to Wayne's management.

50. In response, Medco singled out Kim for criticism and disciplinary action, harassed him, and ultimately fired him.

51. Medco wrongfully retaliated against Kim for investigating and reporting to Medco the creation of false patient records and their use by Medco to fraudulently obtain Medicaid and Medicare reimbursement, in violation of 31 U.S.C. § 3730(h)..

52. Kim has been damaged by Medco's wrongful conduct.

RELIEF DEMANDED

WHEREFOR, Kim demands judgment be against Medco as follows:

A. On Count I, damages including, but not necessarily limited to, two times the amount of back pay, interest on back pay, front pay, and compensatory damages, as provided by 31 U.S.C. § 3730(h);

C. All reasonable expenses that were necessarily incurred in prosecution of this action, plus all reasonable attorneys' fees, interest, and costs, as provided by 31 U.S.C. §§ 3730(d) and (h);

and such other relief as the court deems appropriate.

DEMAND FOR JURY TRIAL

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Kim hereby demands trial
by jury.

Dated: New York, New York
August 20, 2008

Timothy J. McInnis [TM 7151]
Richard F. Bernstein, of counsel [RB 3091]
LAW OFFICE OF TIMOTHY J. McINNIS

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