IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA ex rel. JOHN DOE AND JANE DOE Plaintiffs, -against- AHS HOSPITAL CORP., ATLANTIC HEALTH SYSTEMS, INC., OVERLOOK HOSPITAL, SUMMIT MEDICAL GROUP, EMERGENCY MEDICAL ASSOCIATES OF NEW JERSEY, HOSPITALIST ASSOCIATES, INC., JOHN ROE, M.D. 1 TO JOHN DOE, M.D. 100 (ONE HUNDRED OVERLOOK HOSPITAL STAFF PHYSICIANS), INGLEMOOR REHABILITATION & CARE CENTER, RUNNELLS SPECIALIZED HOSPITAL, SOUTH MOUNTAIN HC, CAREONE, GENESIS HEALTHCARE, DAVID SCHRECK, M.D., AND SAMIR PATEL, M.D., Defendants.	Civil Action No. FILED UNDER SEAL AS REQUIRED BY 31 U.S.C. § 3730(b)(2)

QUI TAM COMPLAINT AND DEMAND FOR JURY TRIAL

1. This is a civil action by JOHN DOE and JANE DOE ("Relators") on their own behalf, and on behalf of the United States, against AHS Hospital Corp., Atlantic Health Systems, Inc., Overlook Hospital, Summit Medical Group, Emergency Medical Associates of New Jersey, Hospitalist Associates, Inc., John Roe, M.D. 1 to John Doe, M.D. 100 (One Hundred Overlook Hospital Staff Physicians), Inglemoor Rehabilitation & Care Center, Runnells Specialized Hospital, South Mountain HC, CareOne, Genesis HealthCare, David Schreck, M.D., and Samir Patel, M.D., under the *qui tam* provisions of the False Claims Act, 31 U.S.C. §§ 3729-3733 (the "FCA"), for treble damages, civil penalties, and other relief arising from

defendants' requests for Medicare payments from the United States Department of Health and Human Services ("HHS"), Center for Medicare and Medicaid Services ("CMS").

NATURE AND OVERVIEW OF ACTION

2. This is a health care fraud case. In connection with the submission of claims for Medicare Part A and Part B reimbursements, from at least as early as 2002 to at least as late as the filing of this complaint, in the District of New Jersey, and elsewhere, the Defendants knowingly presented, and caused to be presented, to an officer and employee of CMS, false and fraudulent claims for payment and approval; knowingly made, used, and caused to be made and used, false records and statements to get false and fraudulent claims paid and approved by CMS; and conspired to defraud CMS by getting false or fraudulent claims allowed or paid, all in violation of 31 U.S.C. §§ 3729(a)(1), (2) and (3).

3. More specifically, this case concerns improper Medicare Part A and Part B billing for hospital and physician services for patients who were either admitted into, or treated on an outpatient basis at, Overlook Hospital in Summit, New Jersey, and, who frequently were subsequently discharged to skilled nursing facilities ("SNFs") in the surrounding area. Among other things, this scheme to submit false and fraudulent claims to CMS involved the following:

- (a) Billing (under Medicare Part A) for "inpatient hospital services" and physician services provided to Overlook Hospital patients, when, as Defendants knew or should have known, these patients did not meet the criteria for inpatient admissions. Such inpatient hospital and physician services should have been either billed (under Medicare Part B) as "extended outpatient observation services" or "treatment room services," or not billed separately from the underlying treatment services;

- (b) Billing (under Medicare Part B) for either extended outpatient observation services or treatment room services to patients who Defendants knew or should have known did not meet the criteria for such care;

- (c) Failing to correct claims for inpatient admissions when they became known to Defendants prior to the patients being discharged from Overlook Hospital;

- (d) Failing to inform physicians and patients when Overlook Hospital changed patients' status from Medicare Part A to Part B via Code 121;

- (e) Billing Medicare (under Part A) for unnecessary inpatient hospital and physician services at Overlook Hospital, including by extending acute inpatient lengths of stay beyond what was medically necessary (typically extending such stays by approximately two days); and

- (f) Billing Medicare (for Skilled Nursing Facility Benefits under Part A) for "post-hospital extended care services" (also known as "subacute" rehabilitation, therapy or medical services) provided to patients discharged from Overlook Hospital and transferred to neighboring SNFs where, as Defendants knew or should have known, the patients never met the illness and treatment eligibility criteria for such services and/or where the patients had been kept at Overlook Hospital on an inpatient basis for certain periods of time (namely, at least three consecutive days) in order to qualify them for Medicare reimbursement at such skilled nursing facilities, and not because of any medically necessary reason.

4. Defendants sought Medicare reimbursements for the above-listed services that they either were not entitled to at all or at charges that were significantly higher than they would have received if properly billed pursuant to Medicare regulations and policies.

5. As a result of submitting their false and fraudulent claims to CMS, Defendants wrongly obtained a substantial amount of Medicare funds, in an amount to be determined at trial.

6. Upon information and belief, CMS would not have reimbursed Defendants' false and fraudulent claims had it known the true facts and circumstances surrounding them.

PARTIES, PERSONS AND ENTITIES

7. For pleading purposes the United States, through its agency HHS, is the real plaintiff-party in interest in the False Claims Act *qui tam* causes of action alleged in this complaint. HHS is located at 200 Independence Avenue, SW, Washington, DC 20201. CMS, which was formerly known as the Health Care Financing Administration (or "HCFA"), is the HHS office responsible for the administration of Medicare. CMS is located at 7500 Security Boulevard, Baltimore, Maryland, 21244-1850. CMS has issued numerous manuals, guidelines and policy statements to hospitals concerning, among other things, the criteria for billing patients for both inpatient hospital services and extended outpatient observation care.

8. CMS contracts with private insurance carriers to administer the Medicare program. It has separate arrangements with insurers under Parts A and B of the Medicare program. The insurance carriers that manage Medicare Part A claims for hospital reimbursements are known as "fiscal intermediaries." BlueCross Blue Shield of Tennessee, d/b/a Riverbend Government Benefits Administrator ("Riverbend") is the fiscal intermediary responsible for receiving and processing the Medicare Part A claims at issue in this complaint. Its principal offices are located at 730 Chestnut Street, Chattanooga, Tennessee 37402, and its telephone number is (877) 296-6189. Riverbend's CMS contractor's policy number is 080-01 and its contractor number is 00390. Among other things, Riverbend issued guidelines and

policies to various hospitals, including Overlook Hospital, advising them as to CMS' requirements for billing inpatient admissions for acute care and extended observation outpatient services.

9. The insurance carriers that CMS contracts with to manage Medicare Part B claims for medical services are known as "carriers." Empire HealthChoice, Inc. ("Empire") is the carrier responsible for receiving and processing the Medicare Part B claims at issue in this complaint. Empire's executive offices are located at 11 West 42 Street, New York, New York 10036; the offices for its Medicare Part B New Jersey Operations are located at 300 East Park Drive Harrisburg, Pennsylvania 17111, where the telephone number is (717) 565-3494.

10. Healthcare Quality Strategies, Inc. ("HQSI") is a quality improvement organization ("QIO") that contracts with CMS to improve medical care at various health care providers, including acute care hospitals in New Jersey, such as Overlook, by, among other things, implementing a Hospital Payment Monitoring Program ("HPMP"). The objective of the HPMP is to measure, monitor and reduce the incidence of improper fee-for-service inpatient payments to STAC hospitals, including errors in Diagnosis-Related Group ("DRG") assignment, International Classification of Diseases, Ninth Edition, Clinical Modification ("ICD-9-CM") diagnostic coding, provision of medically unnecessary services, and inappropriateness of setting, billing and prepayment denial. HQSI is located at 557 Cranbury Road, Suite 21, East Brunswick, New Jersey 08816 and its telephone number is (732) 238-5570.

11. To meet its HPMP objectives HQSI relies on, among other things, InterQual Level of Care Acute Criteria ("InterQual Criteria") published by InterQual, a subsidiary of McKesson Health Solutions, L.L.C., 275 Grove Street, Suite 1-110, Newton, Massachusetts

02466, (800) 522-6780. These criteria permit the objective evaluation of a health care provider's determination of severity of illness and intensity of service ("SI/IS"), that is, the necessity of services and the correct level of care, including for inpatient admissions and extended outpatient observations. In 1999, HCFA (CMS' predecessor) licensed InterQual Criteria for use in reviewing Medicare inpatient services. CMS subsequently re-licensed InterQual Criteria for such use in 2003.

12. Relator John Doe's identity and background information has been provided to the United States Attorney's Office for the District of New Jersey.

13. Relator Jane Doe's identity and background information has been provided to the United States Attorney's Office for the District of New Jersey.

14. Defendant AHS Hospital Corp. ("AHS") is a private, not-for-profit (IRS 501(c)(3)) regional health care system. Its principal office is located at 325 Columbia Turnpike, Florham Park, New Jersey 07932, and its mailing address is PO Box 1905 Morristown, New Jersey 07962. Its telephone number is (973) 660-3100 and its EIN is 52-1958352. AHS provides hospital health care services at three separate hospital campuses: Overlook Hospital, Morristown Memorial Hospital, and Mountainside Hospital. AHS generates revenues of approximately $1 billion annually for providing patient and physician services to millions of patients, including a large number of Medicare and Medicaid beneficiaries. Joseph A. Trunfio, Ph.D., is President & Chief Executive Officer of AHS.

15. Defendant AHS is a wholly owned subsidiary of defendant Atlantic Health Systems, Inc., ("Atlantic Health Systems"), a private, not for profit (IRS 501(c)(3)) health care system serving over five million people annually in northern and central New Jersey. Atlantic

Health System provides health care services through AHS at the following hospitals and facilities: Overlook Hospital, Atlantic Health, Morristown Memorial Hospital, Goryeb Children's Hospital, Gagnon Heart Hospital, Carol G. Simon Cancer Center, and Atlantic Neuroscience Institute. Atlantic Health Systems' principal office is located at 475 South Street, Morristown, New Jersey 07962. Its telephone number is (973) 660-6100. And, its EIN is 22-3380375. Joseph A. Trunfio, Ph.D., is President & Chief Executive Officer of Atlantic Health System.

16. Defendant Overlook Hospital is a 500-bed community teaching hospital located at 99 Beauvior Avenue, Summit, New Jersey 07902 that participates in the Medicare and Medicaid programs. Overlook Hospital is a short-term acute care ("STAC") hospital, meaning it provides short-term medical treatment for patients having a brief, but severe, illness or injury or who are recovering from surgery-- with the goal of discharging them as soon as the patient is deemed healthy and stable (typically in less than 25 days), with appropriate discharge instructions. Overlook Hospital's ten most commonly handled procedures or diagnoses are: maternity care, heart failure, pneumonia, gastrointestinal bleeding, stroke, appendectomy, sepsis (severe infection), chronic obstructive pulmonary disease, hip fracture repair and atrial fibrillation. It is accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO). Overlook Hospital has adopted the InterQual criteria and Alternative Level of Care Guidelines.

17. Defendant Summit Medical Group ("SMG") is a 120 doctor multi-specialty medical group practice that provides primary and specialty medical care, including to patients that its doctors admit to Overlook Hospital. SMG is located at 1 Diamond Hill Road, Berkeley

Heights, New Jersey 07922 and its telephone number is (908) 273-4300. Dr. David Schreck is the current director of SMG's outpatient clinic and hospitalists group. Doctors at SMG regularly misclassified patients for inpatient services and observation care at Overlook Hospital, as well as provided medical treatment and services that were not medically necessary at these respective level of care. Upon information and belief, SMG Physicians regularly billed the Medicare program (Parts A and B) for such wrongly classified patients and for such unnecessary treatments and services. Additionally, SMG seeks to ensure patients remain within the SMG system at discharge. It effectively influences its admitting primary care physicians and at times its specialists at times dictate what they do with respect to admitting patients and discharging patients and the hospitalists defer to the SMG specialists.

18. Defendant Emergency Medical Associates of New Jersey (EMA) is an emergency physician group practice that is owned by approximately 250 practicing physicians and is constituted as a professional association. EMA has contracts with 18 hospitals in New Jersey and in New York State, including Overlook Hospital, to provide physician and physician-assistant coverage for emergency departments, with a combined volume of approximately 2,000 patients per day. EMA reportedly receives an estimated one third of all emergency department visits in the northern half of New Jersey. EMA is a group of physicians who contract out their services in caring for patients in hospitals (they are known as hospitalists). EMA previously contracted with SMG to do its admissions and it receives referrals from private physicians who did not want to come to the hospital to provide primary care services. Such referring physicians simply signed off their patients to be admitted and managed by EMA physicians. Some of EMA's prior physicians include, Vinod Abraham; Jason Shapiro; Ignacio

Valdes; Evangeline Gutierrez; and David Schreck. EMA's corporate offices are located at 651 Old Mount Pleasant Avenue, Livingston, New Jersey 07039 and its telephone number is (877) 692-4665. At some times relevant to this complaint, EMA was headed by David Schreck, M.D., who has since joined defendant SMG. EMA is currently run by E. Gutierrez. Doctors from EMA routinely submitted claims for inpatient services that were not medically justified. Upon information and belief, EMA Physicians regularly billed the Medicare program (Parts A and B) for such wrongly classified patients and for such unnecessary treatments and services.

19. Defendant Hospitalist Associates, Inc., ("Hospitalist Associates") is located at 16 Edgewood Rd, Summit, NJ 07901 and its telephone number is (908) 522-1776. Hospitalist Associates is a group of physicians who contract out their services in caring for patients in hospitals. Upon information and belief, among its contractual arrangements, Hospitalist Associates manages admissions for Defendant Runnells Specialized Hospital. Hospitalist Associates is headed by Defendant Samir Patel, M.D.

20. Defendants Dr. John Roe 1 to Dr. John Roe 100 are one hundred private medical doctors with admission privileges at Overlook Hospital (the "Staff Physicians") whose true identities are presently unknown. Each of these doctors routinely misclassified patients for inpatient services at Overlook Hospital, as well as provided medical treatment and services that were not medically necessary. Upon information and belief, the Staff Physicians regularly billed the Medicare program (Parts A and B) for such wrongly classified patients and for such unnecessary treatments and services.

21. A STAC hospital's aim is to stabilize a patient's condition and perform a myriad of diagnostic studies to determine the underlying cause of a patient's complaints. Once the

diagnosis is secured and treatment has been selected, the patient is generally discharged to an appropriate setting, depending on his or her needs. Such subsequent treatment is typically carried out in home health, skilled nursing facilities, independent rehabilitation facilities, depending on whether the patient's needs can be managed by family, nurses, rehabilitation therapists, or physicians, respectively. Many of Overlook Hospital's Medicare patients are discharged to subacute rehabilitation facilities, including patients who were improperly admitted to the hospital on an inpatient basis for at least three consecutive days and as a result were improperly deemed eligible for Medicare Part A reimbursement for post-hospital extended care services for up to 100 days stay at a skilled nursing facility.

22. Defendant Inglemoor Rehabilitation & Care Center ("Inglemoor"), is a skilled nursing facility located at 311 South Livingston Avenue, Livingston, New Jersey 07039; its telephone number is (973) 994-0221. Upon information and belief, Inglemoor entered into transfer agreements with various STAC hospitals, including Overlook Hospital, to provide "post-hospital extended care services" (that is, extended care services furnished to an individual after transfer from a hospital in which he was an inpatient for not less than three consecutive days before his transfer) to patients discharged from these hospitals. Pursuant to such a transfer agreement, Inglemoor regularly accepted Medicare patients who were discharged from Overlook Hospital, including Medicare patients who had been wrongly admitted to Overlook Hospital on an inpatient basis. Upon information and belief, Inglemoor regularly billed the Medicare program (Part A) for such wrongly admitted patients. Upon further information and belief, Inglemoor knew or should have known that it improperly billed the Medicare program for patients that were inappropriately admitted to Overlook Hospital on an inpatient basis. In many

instances such patients' conditions did not even warrant subacute rehabilitation, therapy or medical treatment in a skilled nursing facility setting, let alone treatment for inpatient hospital services. Some physicians who admitted these patients to Overlook Hospital and later discharged them to Inglemoor stood to gain personally for such transfers.

23. Defendant Runnells Specialized Hospital ("Runnells"), is a skilled nursing facility located at 40 Watchung Way, Berkeley Heights, New Jersey 07922; its telephone number is (908) 771-5700. Upon information and belief, Runnells entered into transfer agreements with various STAC hospitals, including Overlook Hospital, to provide "post-hospital extended care services" (that is, extended care services furnished to an individual after transfer from a hospital in which he was an inpatient for not less than three consecutive days before his transfer) to patients discharged from these hospitals. Pursuant to such a transfer agreement, Runnells regularly accepted Medicare patients who were discharged from Overlook Hospital, including Medicare patients who had been wrongly admitted to Overlook Hospital on an inpatient basis. Upon information and belief, Runnells regularly billed the Medicare program (Part A) for such wrongly admitted patients. Upon further information and belief, Runnells knew or should have known that it improperly billed the Medicare program for patients that were inappropriately admitted to Overlook Hospital on an inpatient basis. In many instances such patients' conditions did not even warrant subacute rehabilitation, therapy or medical treatment in a skilled nursing facility setting, let alone treatment for inpatient hospital services. Some physicians who admitted these patients to Overlook Hospital and later discharged them to Inglemoor stood to gain personally for such transfers.

24. Defendant South Mountain HC ("South Mountain"), is a skilled nursing facility located at 2385 Springfield Avenue, Vauxhall, New Jersey 07088; its telephone number is (908) 688-3400. Upon information and belief, South Mountain entered into transfer agreements with various STAC hospitals, including Overlook Hospital, to provide "post-hospital extended care services" (that is, extended care services furnished to an individual after transfer from a hospital in which he was an inpatient for not less than three consecutive days before his transfer) to patients discharged from these hospitals. Pursuant to such a transfer agreement, South Mountain regularly accepted Medicare patients who were discharged from Overlook Hospital, including Medicare patients who had been wrongly admitted to Overlook Hospital on an inpatient basis. Upon information and belief, South Mountain regularly billed the Medicare program (Part A) for such wrongly admitted patients. Upon further information and belief, South Mountain knew or should have known that it improperly billed the Medicare program for patients that were inappropriately admitted to Overlook Hospital on an inpatient basis. In many instances such patients' conditions did not even warrant subacute rehabilitation, therapy or medical treatment in a skilled nursing facility setting, let alone treatment for inpatient hospital services. Some physicians who admitted these patients to Overlook Hospital and later discharged them to Inglemoor stood to gain personally for such transfers.

25. Defendant CareOne is a provider of long term care, assisted living, and rehabilitation services, primarily for senior citizens. It operates and manages approximately 25 skilled nursing and rehabilitation centers, including many of the local skilled nursing facilities that had improperly accepted Medicare patients who were discharged from Overlook Hospital

who had been wrongly classified as acute inpatients. CareOne's offices are located at 173 Bridge Plaza North, Fort Lee, NJ 07024; its telephone number is (201) 242-4034.

26. Defendant Genesis HealthCare ("Genesis") is one of the nation's largest long-term care and rehabilitation therapy services providers, delivering care to the over 26,000 residents and patients daily. It provides ShortStay and LongTerm Care services, as well as Specialized Alzheimer's care, orthopedic rehabilitation, ventilator care, dialysis care and Assisted Living services. Genesis has more than 200 health care facilities in 13 eastern states, including, approximately 25 centers in New Jersey, many of which had improperly accepted Medicare patients who were discharged from Overlook Hospital who had been wrongly classified as acute inpatients. Genesis' headquarters are located at 101 East State Street, Kennett Square, PA 19348; its telephone number is (610) 444-6350.

27. Defendant David Schreck, M.D. is the current director of Defendant SMG's outpatient clinic and hospitalists group. At some times relevant to this complaint, he was the head of Defendant EMA.

28. Defendant Samir Patel, M.D. is the head of Defendant Hospitalist Associates.

JURISDICTION AND VENUE

29. This Court has subject matter jurisdiction over the claims alleged in this Complaint under 28 U.S.C. §§ 1331 (Federal question) and 1345 (United States as plaintiff), and the jurisdictional provisions of the False Claims Act, 31 U.S.C. 3739(e).

30. Venue is proper in this district pursuant to 31 U.S.C. §§ 3732(a) and 1391 because at least one of the Defendants can be found, resides, and transacts business in this District; 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.

31. Upon information and belief, there are no pending actions that would be deemed to be related to this action, and further, this Complaint is not based on the facts underlying any such pending action.

32. This action is not precluded by any provisions of the False Claims Act's jurisdiction bar. This action is not brought by a current or former member of the armed services against another member of the armed services arising out of such person's service in the armed forces. Nor, is it brought against a member of Congress, the judiciary or a senior executive branch official and based upon evidence or information already known to the Government. Upon information and belief, this Complaint is not based upon allegations or transactions that are the subject of a civil suit or an administrative civil money penalty proceeding in which the United States is already a party.

33. Upon further information and belief, there has been no "public disclosure" of the matters alleged herein and this action is not "based upon" any such disclosure. Notwithstanding the foregoing, through their first-hand experiences with and observations of with Defendants, Relators John Doe and Jane Doe have "direct and independent knowledge" of the instant allegations. Additionally, Relators John Doe and Jane Doe have "voluntarily provided," and offered to provide, this information to the Government before filing this Complaint. Therefore, to the extent any of these allegations is deemed to have been based upon a public disclosure, Relators John Doe and Jane Doe are "original sources" of this information and as such, they is expressly excepted from any public disclosure bar.

FALSE CLAIMS ACT

34. The federal False Claims Act provides, in pertinent part, that:

> (a) Any person who . . . (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or (3) conspired to defraud the Government by getting false or fraudulent claims allowed or paid
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> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000,[1] plus 3 times the amount of damages which the Government sustains because of the act of that person . . . .
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> (b) For purposes of this section, the terms "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 no proof of specific intent to defraud is required.

31 U.S.C. § 3729.

THE MEDICARE PROGRAM

35. The Medicare Program is governed by Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.* It is a Health Insurance Program that is funded by taxpayer revenue and

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[1]The minimum and maximum penalties were increased in September 1999 to $5,500 and $11,000, respectively, pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990 (Pub. L. 101-410, 104 State. 890, as amended by the Debt Collection Improvement Act of 1996, Pub. L. 104-134, 110 Stat. 1321).

administered by the Government. The program is overseen by the United States Department of Health and Human Services. Medicare was designed to be a health insurance program and to provide for the payment of hospital services, medical services and durable medical equipment to persons over sixty-five (65) years of age and others that qualify under the terms and conditions of the Medicare Program.

Medicare Part A

36. The Medicare Program is divided into distinct parts. One part is for hospital insurance (the "Hospital Insurance Program" or "HI"; it more commonly called "Medicare Part A"). Medicare Part A is financed mostly through employee payroll taxes. It helps cover inpatient care in hospitals, including STAC hospitals and skilled nursing facilities. It also helps cover hospice care and some home health care. Medicare Part A does not cover custodial or long-term care. Medicare Part A pays for covered services and supplies only when they are medically necessary.

Medicare Part B

37. Another part of the Medicare Program is for medical insurance. It is called the "Supplementary Medical Insurance Program for the Aged and Disabled" or "SMI," but is more commonly known as "Medicare Part B." Most Medicare Part B beneficiaries pay a monthly premium for Part B medical insurance. Medicare Part B helps cover the costs of physicians' services and outpatient care. It also covers some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists, and some home health care. Medicare Part B Medical Insurance pays for covered services and supplies only when they are medically necessary.

Medicare Skilled Nursing Facility Benefits

38. Medicare Part A provides limited hospital insurance coverage to eligible persons receiving covered services at approved nursing homes (the "Medicare SNF Benefit"). The Medicare SNF benefit was designed to reduce the length of stay in acute care hospitals and thus reduce the size of Medicare Part A reimbursements. It covers post-hospital skilled nursing care in facilities certified to participate in Medicare. The Medicare SNF benefit, however, was specifically designed to provide only short-term post-hospital subacute and rehabilitative care needs.

39. The inpatient services in an SNF are at a lower level of care than that provided in a hospital, but SNF patients still require skilled nursing or rehabilitation services. Medicare does not pay for custodial care when that is the only kind of care needed. Care is considered custodial when it is primarily for the purpose of helping the patient with personal needs and daily living activities, and the care could be provided safely and reasonably by staff without supervision from persons with professional health education or skill. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, and taking oral medicine.

40. A certified SNF is a facility that has the staff and equipment to provide skilled nursing care, skilled rehabilitation services, and other related health services and that meets the conditions of participation specified in regulations.

41. Skilled nursing care means care that can only be performed by or under the supervision of licensed nursing personnel. Skilled rehabilitation services include physical

therapy, occupational therapy, and speech pathology services performed by or under the supervision of a qualified professional.

Covered SNF Care

42. If the SNF patient meets the level-of-care eligibility and coverage criteria (see below), the following inpatient SNF services are covered:

a. Nursing care provided by or under the supervision of a registered professional nurse.

b. Bed and board in a semiprivate room (including special diets) in connection with the furnishing of nursing care.

c. Physical therapy, occupational therapy, or speech pathology services furnished by an SNF or by other facilities under arrangement with the SNF.

d. Psychological therapy for temporary depression or for dementia.

e. Drugs, biologicals, supplies, appliances, and equipment that are for use in the SNF and that are ordinarily furnished by the SNF for the care and treatment of inpatients.

f. Medical services of interns and residents-in-training under an approved teaching program of a hospital with which the SNF has in effect an agreement.

g. Social services, activities, and other services necessary to the health of the patient.

43. Services considered beyond the scope of Medicare coverage include personal convenience items (such as television and telephone), private duty nurses, extra charges for a private room (unless needed for medical reasons), and the first three pints of blood in a benefit

period. Physician services furnished to a beneficiary in an SNF are not covered under the SNF benefit, but are covered under Medicare Part B.

Level of Care Eligibility Criteria

44. Medicare hospital insurance (Part A) helps pay for care in a Medicare-participating SNF if all of the following six conditions are met:

a. The patient's condition requires daily skilled nursing or skilled rehabilitation services that, as a practical matter, can only be provided in an SNF.

b. The beneficiary was an inpatient in a hospital at least three (3) consecutive days before being admitted to a participating SNF.

c. The beneficiary was admitted to an SNF within 30 days after leaving the hospital.

d. The care in the SNF is for a condition that was treated in the hospital or for a condition that arose while the beneficiary was receiving care in the SNF for a condition that was treated in the hospital.

e. A medical professional certifies that the beneficiary needs skilled nursing or skilled rehabilitation services on a daily basis.

f. The Medicare intermediary does not disapprove the stay.

45. Medicare Part A does not pay for the stay if the beneficiary needs skilled nursing or rehabilitation services only occasionally, such as once or twice a week, or if the patient does not need to be in an SNF to get the skilled services. Also, Medicare Part A does not pay for the stay if the beneficiary is in an SNF for only custodial care.

The SFN Benefit

46. Medicare Part A allows a maximum of 100 covered days of SNF care per beneficiary per episode of illness. An episode of illness (or benefit period) begins on the first day the beneficiary received hospital services and ends when the patient has not been a hospital or SNF patient for 60 consecutive days. If a beneficiary is eligible for SNF care, Medicare pays for all covered SNF expenses for the first 20 days. After the 20th day, patients are required to pay for part of their SNF care in the form of daily coinsurance payments. After 100 covered days, beneficiaries are financially responsible for all of the expenses they incur for SNF care. Those whose personal resources do not allow them to pay for all the care they need can apply to Medicaid for financial assistance.

LEGAL AND REGULATORY FRAMEWORK

47. The statutory and regulatory support for the rules regarding inpatient admissions, extended outpatient observation services and treatment room services are found in the following laws, regulations and policy statements, among others:

65 FR 18457

CMS Pub 100-1, 5 §10.2

CMS Pub 100-2, 1 §10

CMS Pub 100-2, 6 §10

CMS Pub 100-2, 6 §70.4

CMS Pub 100-4, 6 §10, 9 §30.2, 23 §10, 24 §20.2, 25 §50.1 & 60, 28 §30.2

CMS Pub 100-4, 4 §290

CMS Pub 100-4, 3 §50.1, 25 §80.2.1

CMS Pub 100-4, 29 §60.27.3

MIM Transmittal No. 1604 09-97 BILL REVIEW 3604 Rev. 13-3-1726 (12-98 BILLING PROCEDURES 460 Rev. 10-738)

MIM Transmittal No. 1689

MIM transmittal No. 1689

OPPS Training Manual Chpt IV: clinical implications of the OPPS-Medical Review Decisions

OPPS Training Manual Chpt V: Outpatient PPS Payment Calculations: Packaging

PRO 19-1010.C

PRO 19-4110.A

Social Security Act § 1833(e); and

Social Security Act §1862(a)(1)(A).

Social Security Act.

48. Sections 1862 (a) (1) and (2) prohibit payment for items and services which are not reasonable and necessary or which the individual furnished such items or services has no legal obligation to pay. It provides:

> (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—
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> (1)(A) 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, [or[
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> ***
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> (2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for, except in the case of Federally qualified health center services;...

42 U.S.C. §§ 1395y(a)(1) and (2).

49. Post-hospital extended care services. The term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. 42 U.S.C. § 1395x(i).

50. Title XVIII of the Social Security Act, Section 1833(e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim. It provides that:

> (e) No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

42 USC § 1395l.

Code of Federal Regulations

51. Code of Federal Regulations Section 421.100 (a) (2) directs the intermediary to take appropriate action to reject or adjust the claim if the services furnished were not reasonable, not medically necessary, or not furnished in the most appropriate setting; or if the claim does not properly reflect the kind and amount of services furnished. The regulations at 42 C.F.R. § 421.100(a)(2), provide that:

> The intermediary takes appropriate action to reject or adjust the claim if--
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> (i) The intermediary or the QIO determines that the services furnished or proposed to be furnished were not reasonable, not medically necessary, or not furnished in the most appropriate setting; or
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> (ii) The intermediary determines that the claim does not properly reflect the kind and amount of services furnished.

42 C.F.R. § 421.100(a)(2).

CMS-Issued Guidelines and Policies

52. CMS has issued a number of guidelines and policies statements regarding billing of inpatient hospital services and extended outpatient observation services, including the following:

a. CMS Pub 100-1 §10.2 [Medicare Hospital Manual Section 10-210] is the primary reference for Medicare inpatient status determinations.

b. CMS Pub 100-2, 6 §70.4 [Hospital Manual 10-230.6] defines extended observation and delineates the appropriate use of that service.

c. CMS Pub 100-2, 6 §20.1 [Hospital Manual 10-230.1] discusses the appropriate billing of "Day Stay" patients.

d. CMS Pub 100-4, 3 §140.2.3 & 30 §20.1 [Hospital Manual 10-414.8.A] delineates provisions regarding reimbursement for a patient that is transferred between hospitals.

e. CMS Pub 100-4, 3-§10.4 [Hospital Manual 10-407] discusses reimbursement for specialized services that do not necessitate a transfer.

f. CMS Pub 100-2, 6 §20.1 [Hospital Manual 10-230.1 specifies that services provided to an inpatient or outpatient of a hospital are covered only when that primary hospital bills Medicare for the services.

g. MIM Bill Review and PRO. The basis for this policy [LMRP L1281] is MIM BILL REVIEW [13-3-3604 Fl. 42 code 76x] which states that "Payer should establish written guidelines which identify coverage of observation services", and PRO 1010 which

instructs the PRO to "identify and seek correction of situations that if continued, would result in violations under §1156 of the Act. [PRO 19-1010.C].

53. Outpatient observation services (revenue code 0762) are defined in 3112.8(A) of the Intermediary Manual and 230.6(A) of the Hospital Manual published by the CMS as:

> Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests.
>
> Additionally, subpart (E) of the Hospital Manual section referenced above defines services that are not covered as outpatient observation. These include:
>
> • Observation services which exceed 48 hours, unless the fiscal intermediary grants an exception based on the particular facts of the case.
> • Services which are not reasonable or necessary for the diagnosis or treatment of the patient but are provided for the convenience of the patient, his or her family, or physician....
> • Services which are covered under Part A, such as a medically-appropriate inpatient admission, or as part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payment for those diagnostic services. Observation should not be billed concurrently with therapeutic services such as chemotherapy.
> • Standing orders for observation following outpatient surgery....
> • Services which were ordered as inpatient services by the admitting physician, but billed as outpatient by the billing office.
> • Claims for inpatient care such as complex surgery clearly requiring an overnight stay and billed as outpatient.
> Prior to August 2000, hospitals were separately reimbursed for observation services on a cost basis. Outpatient observation services were charged by number of hours, with the first observation hour beginning when the patient is placed in the observation bed (beginning and ending times are rounded to the nearest hour). With the start of the Outpatient Prospective Payment System (OPPS) in August 2000, payment for observation services were no longer reimbursable as separate payments, they were included as part of the OPPS payment amount for outpatient

procedures. Although CMS will continue to package observation services into surgical procedures and most clinic and emergency visits, starting January 1, 2002, CMS will separately pay for observation services involving three medical conditions. As published in the November 30, 2001, Federal Register, CMS will separately pay for observation services relating to chest pain, asthma, and congestive heart failure.

Riverbend-Issued Guidelines and Policy Statements.

54. Effective since June of 2002, Riverbend has issued guidelines and policy statements in the form of a Local Medical Review Policy ("LMRP"), Local Coverage Determination ("LCD"), and Companion Article to instruct providers on proper Medicare billing for inpatient hospital services and extended outpatient observations services.

LMRPs

55. LMRPs are the coverage policies that are developed by the Medicare Fiscal Intermediaries and Insurance Carriers and apply directly to claims made to the Fiscal Intermediaries and Insurance Carrier for Coverage under Medicare. LMRPs outline how local fiscal intermediaries and carriers will review claims to ensure that they meet Medicare coverage and coding requirements. They specify under what clinical circumstances a service is covered and correctly coded. An LMRP includes a description of the service, specific procedure codes, and for each of these procedures, a list of covered and non-covered diagnostic codes. LMRPs are issued separately for various types of medical services. There are hundreds of LMRPs are in existence for each local fiscal intermediary or carrier. In general, fiscal intermediaries and carriers have wide freedom to determine coverage; the only restriction is that their policies not directly conflict with a National Coverage Decision issued by CMS on the same issue. LMRPs have been defined by CMS as "an administrative and educational tool to assist providers, physicians, and suppliers in submitting correct claims for payment" within a specified

geographic area. However, the major goal of these local policies is to prevent over-utilization of clinical services paid by CMS. Their impact on providers and beneficiaries can be to limit coverage or to deny claims outright.

LCDs compared to LMRPs

56. LCDs were established by Section 522 of the Benefits Improvement and Protection Act of 2000 ("BIPA") (42 U.S.C. § 1395ww). They represent a decision by a fiscal intermediary or carrier as to whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) (42 U.S.C. § 1395y(a)(1)(A)) of the Social Security Act (i.e., a determination as to whether the service is medically reasonable and necessary). The material difference between an LCD and an LMRP is that an LCD consists only of information bearing on the issue of medical "reasonableness and necessity," while an LMRP may also contain category or statutory provisions.

57. The final rule establishing LCDs was published November 11, 2003. Starting on December 7, 2003, CMS's contractors (fiscal intermediaries and insurance carriers) began issuing LCDs instead of LMRPs. Between December 7, 2003 and December 31, 2005 such contractors converted all existing LMRPs into LCDs and articles. Following the conversion to LCDs any additional non-reasonable and necessary language a contractor wished to communicate to providers had to be done through a "companion article."

Companion Articles

58. A companion article to a policy represents a compilation of Medicare regulations that bear on the relevant issue (for example, in this case, extended outpatient observation and brief inpatient admissions), and summarizes their impact as it applies to correct billing. It

provides clarification regarding both coverage and billing issues, and also defines the interpretation of both the fiscal intermediary and the Quality Improvement Organization ("QIO") with respect to Medicare regulations and CMS guidelines and policy statements. As such it represents a joint policy statement that reflects the views of all entities. Article.

The LMRP, LCD and Article Relevant to this Complaint

59. Relevant LMRP. LMRP for Acute Care: Inpatient, Observation and Treatment Room Services (L1281) (effective dates June 1, 2002 through December 30, 2005).

60. Relevant LCD. LCD for Acute Care: Inpatient, Observation and Treatment Room Services (L1281) (effective dates December 31, 2005 to present). This LCD exists to support the medical necessity determinations with respect to observation.

61. Relevant Companion Article. Article A38209 - Acute Care: Inpatient, Observation and Treatment Room Services (effective date 12/31/05). Article A38209 - Acute Care: Inpatient, Observation and Treatment Room Services (effective date 12/31/05) is the companion article issued by Riverbend to accompany LCD for Acute Care: Inpatient, Observation and Treatment Room Services (L1281) (effective dates December 31, 2005 to present). It was deemed consistent with insurance carrier instructions to the physicians regarding the fundamental decision to admit patients to hospitals.

62. Although LMRD (and later LCD) L1281 have been revised and reissued a number of times, all such changes were minor and do not affect the billing issues raised in this complaint. The revision history as follows:

a. 09/08/2005 Removed reference to national lab test requirement for G0244 that was rescinded effective 01/01/2005.

b. 08/06/2004 Crosswalked references to online manual.

c. 07/17/2003 Addition of codes G0263 and G0264 under CPT/HCPCS Code section (FR Nov 1, 2002 OPPS 2003 update).

d. 01/16/2003 Added new ICD-9 CM codes to the list of Congestive Heart Failure, in conformance to PM A-02-111.

e. 11/07/2004 - The description for CPT/HCPCS code G0244 was changed in group 1.

f. 11/26/2005 - CPT/HCPCS code G0244 was deleted from group 1.

g. 11/26/2005 - CPT/HCPCS code G0263 was deleted from group 1.

h. 11/26/2005 - CPT/HCPCS code G0264 was deleted from group 1.

i. The LMRP was converted to an LCD on 12/30/2005.

j. 07/08/2007 - The description for CPT/HCPCS code G0379 was changed in group 1.

k. 10/02/2007 - Frequently Asked Questions restored to Appendices. Typographical change in Documentation Requirements UB-92 changed to UB-04.

l. 11/10/2007 - The description for CPT/HCPCS code G0379 was changed in group 1.

The Key Aspects of LMRP 1281, LCD 1281 and Article A38209

63. The determination of an inpatient or outpatient status for any given patient is specifically reserved to the admitting physician, although that physician has Medicare guidelines he is expected to follow. The decision must be based on the physician's expectation of the care that the patient will require. The general rule is that the physician should order an

inpatient admission for patients who are expected to need hospital care for 24 hours or longer and treat other patients on an outpatient basis. An inpatient admission is not covered when the care can be provided in a less intensive setting without significantly and indirectly threatening the patient's safety or health. Although in many institutions there is no difference between the actual medical services provided in inpatient and observation settings, in such cases the designation still serves to assign patients to an appropriate billing category. The correct physician application of Medicare patient status guidelines is therefore always critically important.

64. Observation services require the use of a bed and periodic monitoring to evaluate an outpatient condition or determine the need for possible inpatient admission. Observation may not be used as a substitute for a medically necessary inpatient admission, nor may it be used solely for the convenience of a patient, physician or facility. Observation generally does not exceed 24 hours and never (practically speaking) exceeds 48 hours.

65. Treatment room services are not synonymous with observation and are used to reimburse for facility usage associated with minor procedures where those facility services are not otherwise reimbursed or bundled.

66. A person is considered an inpatient if he is formally admitted based on the physician's expectation of a need for an appropriate inpatient stay. If the patient dies, is transferred, leaves AMA or recovers in a shorter period of time, an inpatient admission should still be billed. The justification for the admission, then, is based on the information available at the time of admission. Subsequent information may support a physician's "hunch" that the patient needed inpatient care, but never serves to refute that original determination.

67. A patient with a known diagnosis entering the hospital for a minor procedure or treatment that is expected to require a short stay (less than 24 hours) is considered an outpatient regardless of the time of arrival or the use of a bed and regardless of whether or not the stay spans two actual calendar days. Conversely a patient should be admitted for a minor procedure if comorbidity suggests that a 24-hour stay will be medically necessary. Thus, in general, expected stays of less than 24 hours should be outpatient while expected stays of greater than 24 hours should be inpatient. Note that this decision is the physician's, based on his initial expectation, and is not a facility determination based on the actual length of stay.

68. Observation is appropriate if a serious condition can probably be ruled out in less than 24 hours or if an identified medical condition is likely to abate with less than 24 hours of therapy. If observation is associated with another outpatient service (procedure or ER evaluation), there should be a clear event or decision point that triggers an order or physical transfer to mark the beginning of the observation period. There must be medical necessity for observation beyond the usual recovery period, as hours of the usual recovery time associated with the procedure are already reimbursed with the procedure. Brief observation stays following emergency room evaluation are not covered if those services are normally provided within the time frames and facilities of an emergency visit.

69. Certain diagnoses and procedures generally do not support an inpatient admission, and fall within the definitions of outpatient observation. Specific medical necessity, though, is always determined on a case-by-case basis. Uncomplicated presentations of chest pain (rule out MI), mild asthma/COPD, mild CHF, syncope and decreased responsiveness, atrial arrhythmias and renal colic are all frequently associated with the expectation of a brief (less

than 24-hour) stay unless serious pathology is uncovered. Routine cardiac catheterization, electrophysiologic mapping, and renal dialysis are usually performed with a similar short stay expectation and are thus usually outpatient procedures. The same is also true for TIA, which is one of the most common diagnoses that was misused for admitting patients into Overlook Hospital: many patients with anemias were admitted solely for blood transfusions, which is considered an outpatient service and would not meet observation criteria.

70. An inpatient claim may be denied for a lack of an appropriate physician order, a lack of medical necessity or, as in the case of an aborted admission process, a service (the inpatient stay) that was never rendered. An outpatient claim may have observation hours denied due to the lack of a physician order, lack of medical necessity (e.g. following an uncomplicated procedure or when provided for convenience), or inappropriate billing (routine preparation and recovery time, services exceeding 48 hours). The entire outpatient claim may be denied for inappropriate billing (care clearly necessitating a 24-hour stay) or for lack of medical necessity.

71. Medical review of hospital claims, both inpatient admission and outpatient observation, will be based upon an attempt to find documentation that supports the existence of each of the following critical elements:

1. An INPATIENT claim must contain:

a) A valid order to admit (the decision rests with the MD)

b) Execution of the order to admit (a formal admission of the patient)

c) Some provision of inpatient services, such as patient movement and execution of some admission orders (service was actually rendered)

d) Medical necessity for an inpatient stay (services must be Reasonable & Necessary for

an inpatient stay)

e) Coding (DRG) that is consistent with the documentation (services billed as rendered)

2. An OUTPATIENT claim must contain:

a) A valid order for services such as observation, radiology and lab procedures, etc BUT no valid order to admit to inpatient (Physician order)

b) Execution of the orders consistent with their wording (service rendered as ordered)

c) Medical necessity for the services provided (service Reasonable & Necessary)

d) Correct coding (service billed as rendered)

72. The physician may modify his order at any time prior to the completion of the service (i.e. prior to discharge) as long as this modification only serves to make his actions more consistent with his initial expectation and his instructions in the hospital manual. The initial expectation itself is not alterable, and an order may not be modified after the completion of the service. If the physician's written order is ambiguous or inconsistent with behavior that suggested a different intent, the physician may clarify that order (intention) at any time prior to initial facility billing. However, in order to change the level of care, the patient has to physically be in the hospital bed, otherwise the original, written level of care governs. If the patient has been discharged from the bed and the level of care should have been downgraded to observation, the hospital is required to bill that service under Medicare Part B, not Part A.

73. Medical records will be evaluated to determine the consistency between the physician order (physician intent), the services actually provided (inpatient or outpatient) and the medical necessity of those services, including the medical appropriateness of the inpatient or observation stay.

74. When billing observation or treatment room services the appropriate revenue code must be used and the units field must reflect the number of hours provided. The medical record must clearly support the medical necessity for observation and should include a timed order to observe which will support the number of hours billed. G0244 should be appended for medically necessary observation stays of greater than 8 hours when the observation is for a diagnosis of chest pain, asthma or CHF.

InterQual Criteria

75. McKesson's InterQual Level of Care Criteria are used to review decisions to admit patients and the appropriateness of their level of care. It sets for objective criteria for determining extended observation status, namely, six to 24 hours of observation care, as well as, for critical care, intermediate care and acute care.

76. The InterQual Criteria also establish Alternative Level of Care Guidelines ("ALOC Guidelines"). They are used to assist the reviewer in identifying the safest and appropriate level of care options to be provided for discharged patient. These alternative levels of care include, long-term acute care, acute rehabilitation, subacute rehabilitation, subacute therapy, skilled therapy, subacute medical care, skilled medical care and home care.

Overlook's Statements re Inpatient Admissions and Outpatient Observations

77. Beginning in or about 2006, Overlook Hospital repeatedly issued written notices to attending physicians regarding proper use of inpatient hospital services and outpatient observation services. Notwithstanding that information, attending physicians at Overlook Hospital continue to admit patients for inpatient hospital services when the InterQual Criteria have not been met.

78. Overlook Hospital has issued pamphlets to patients regarding outpatient observation services explaining some of the differences between these and inpatient hospital services. Overlook Hospital has issued pamphlets to physicians (by fax and by intra-hospital mail) regarding outpatient observation services explaining some of the differences between these and inpatient hospital services.

Utilization Review Plans

79. Hospitals must maintain an effective utilization review ("UR") plan on a continuing basis to assure the medical necessity of the services and promote the most efficient use of available health facilities and services. The detailed requirements for an acceptable UR plan are in the Conditions of Participation ("CoPs") for Hospitals. See Medicare Hospital Manual, Chapter II Section 290; see also 42 C.F.R. § 482.30.

80. A UR committee consisting of two or more practitioners must carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in 42 C.F.R. § 482.12(c)(1).

81. The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of—

(i) Admissions to the institution;

(ii) The duration of stays; and

(iii) Professional services furnished, including drugs and biologicals

Review of admissions may be performed before, at, or after hospital admission.

82. The determination that an admission or continued stay is not medically necessary— (i) May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified of 42 C.F.R. § 482.12(c), concur with the determination or fail to present their views when afforded the opportunity; and (ii) Must be made by at least two members of the UR committee in all other cases.

83. If the UR committee determines that the patient requires services other than inpatient hospital or extended care services (such as custodial, outpatient, or home health care), it should find, without regard to the availability of such kinds of care, that further inpatient hospital stay is not medically necessary. Covered inpatient hospital or extended care services should not be considered as an alternative to noncovered or noninstitutional services.

84. Although the fiscal intermediary will accord great weight to the decision made by the UR committee, the final determination regarding reimbursement under the program rests with the intermediary.

DEFENDANT'S FRAUDULENT SCHEMES

General Allegations of Fraud

85. Even though CMS promulgated regulations in 2002 requiring Medicare Part B billing for observation level of care when its criteria were met, Overlook Hospital and virtually every one of its attending physicians ignored that regulation until at least in or about September 2006, when Overlook Hospital began to monitor and guide physicians regarding compliance with the observation services mandate from CMS. Since then the number of observation cases at Overlook Hospital has averaged cases 50 per month which are managed by the medical/surgical unit (this excludes cases handled by the Chest Pain Observation

Unit). However, prior to September 2006, the facility and its attending physicians exhibited no concern about assigning the proper level of care and virtually all Medicare patients were admitted to full inpatient status and billed under a DRG by both the facility and by nearly every physician on its staff.

86. Between in or about 2002 through in or about 2006, Medicare patients were routinely admitted to Overlook Hospital who presented with initial diagnoses that are commonly managed under observation. The more common observation diagnoses included, but are not limited to: Anemia, Transient Ischemic Attack ("TIA"), Gastroenteritis, Syncope and Collapse, Dizziness and Giddiness, Chest Pain, Abdominal Pain, Non-Psychotic Brian Syndrome, Dehydration, Constipation, Malaise and Fatigue and Diabetes. Oftentimes these patients would never meet admission criteria. However, significant numbers of Medicare patients with these initial diagnoses were fraudulently admitted into the hospital, their lengths of stay were often extended without regard to medical necessity (staying around four to five days when they should have been managed as observation for 23 to 48 hours at most) and some they were discharged and transferred to SNFs, which also improperly billed Medicare Part A for post-acute alternate rehabilitation services.

87. During the period from in or about 2002 to in or about 2006, there was little if any utilization review at Overlook Hospital that related to observation care. The Hospital never addressed with its medical staff the difference between inpatient admission and observation level of care criteria. Overlook Hospital did not address InterQual Criteria, or CMS and Hospital documentation standards its medical staff.

88. Since September 2006, Overlook Hospital has frequently identified many improperly admitted Medicare patients and, where the patients have not yet been discharged, the hospital has at times converted them to observation billing status under so-called "Code 44" and does not let them go through as Part A claims.

89. From in or about 2006 until in or about January 2008, Overlook Hospital did not have a properly constituted UR Committee. The corporate compliance department at AHS and the administration at Overlook Hospital were well aware of this regulatory violation.

90. As of the date of this complaint, many doctors with admitting privileges and emergency room physicians at Overlook Hospital continue to balk at assigning the observation status and lack sufficient coding training and information to effectively consider patients for this level of care.

91. For example, Dr. Samir Patel, head of Hospitalist Associates, a large hospitalist group, is billing for interim days for observations cases. Under Medicare regulations observation cases are generally to be for less than 23 hours and no more than 48 hours. Patients needing acute care for longer periods and who meet admission criteria are adjusted to inpatient admission and subsequently discharge. There is no provision for interim billing days for observation stays. However, Dr. Patel is billing Medicare where patients are being seen for physician visits beyond the initial visit and discharge visit.

92. Upon information and belief, a significant number of the attending physicians at Overlook Hospital continue to bill for inpatient physician services under Medicare Part A even though Overlook Hospital has deemed these patients observation cases and is billing Medicare under Part B, Code 121.

93. It is not uncommon for patients who came into the ED on the weekends to end up on the Part B Code 121 list. Upon information and belief, this is because there are fewer UR personnel at the hospital on weekends. Without such oversight the medical staff or the ED physicians often disregard regulatory constraints with respect to levels of care. As a result, the patients are admitted to inpatient. Subsequent retrospective review has identified inappropriate inpatient admissions which have then been reassigned to Medicare Part B under Code 121. Overlook Hospital has over 100 cases on the so-called "Inpatient Part B List."

94. Physicians continue to miscategorize observation patients as inpatients because they have failed to apprise themselves of the InterQual Criteria as they relate to inpatient or observation level of care and have not been adequately informed on the used of such criteria by Overlook Hospital. Upon information and belief, some of the attending physicians are influenced by ignorance, habit and/or their compensation.

95. Upon information and belief a number of physicians with admitting privileges at Overlook Hospital have financial ties to SNFs that have transfer agreements with Overlook Hospital. For example, Dr. fnu Ippilito is the Medical Director of Manor Care; Dr. Blaustien is the Medical Director at Defendant Inglemoor; Dr. Schulman is affiliated with Cornell Hall; and Dr. Barry Freeman is affiliated with Defendant Genesis.

96. Upon information and belief, the Emergency Department doctors at Overlook Hospital may be rewarded financially for admitting patients to the facility. As a result they strive to admit patients who may only be eligible for observation level of care.

97. Overlook Hospital has an unusually high percentage of inpatient admissions, as well as, a high number of observation conversions (so-called "Code 44's"). Approximately

20% of 2007 admissions to observation were done so after the patients were first improperly admitted as inpatients and then converted to observation through a Code 44. Additionally, nearly one-third of these patients stay at Overlook Hospital for more than 48 hours due to the delay in identifying them as observation patients, preparing them and their families for the transition from inpatient to observation status, and the slow pace of the physician management.

98. Upon information and belief, at times, certain SNFs admit Overlook Hospital transfer observation cases into their rehabilitation facilities at the acute rehabilitation level of care when the patients do not meet this alternative level of care criteria. Thereafter the SNFs improperly bill Medicare Part A for such services. This was especially evident for Kessler Institute for Rehabilitation Medicine, Runnels Specialized Hospital, Rehabilitation Institute of Morristown Memorial ("RIMM").

99. The following SNFs were involved in various types of Medicare billing fraud in connection with discharged Overlook Hospital patients:

Arbor Glenn

Berkley Hts Convalescent

CareOne Morristown and Livingston

Cornell Hall

Clark Nursing and Rehabilitation Ctr

Cranford Extended Care

Genesis Westfield and Genesis

Greenbrook Manor

Glenside Nursing Home

Inglemoor

Manor Care

South Mountain Rehab Ctr

Summit Ridge Nursing and Rehab Ctr

Rehab Institute of Morristown (RIMM)

Kessler Rehab Center

Runnels Specialized Care Center

St Cloud

South Mountain, and

Summit Ridge.

100. Not only did Medicare part more money than it should have to Overlook Hospital and the attending physicians as a result of this fraudulent activity, but the patient were also exposed to greater health risks than necessary as a result of prolonged exposure to hospital-caused infections and errors.

Specific examples of false and fraudulent claims

101. Shown below is a list of approximately 90 patients who were billed by Overlook Hospital from in or about 2006 to in or about 2008 under Medicare Part B, Code 121, meaning that these 90 patients were improperly admitted into Overlook Hospital on an inpatient basis because they did not meet the criteria for inpatient admission and at times the attending physician refused to change their classification to observation status. Upon information and belief, the attending physicians listed below continued to bill the Medicare Program under Part

A for in hospital physician services even after Overlook Hospital changed the patients' billing status to Medicare Part B.

ACCOUNT NUMBER	MEDICAL RECORD NO	ATTENDING PHYSICIAN NAME	ADMIT DATE	DISCHARGE DATE	PRINCIPAL DIAGNOSIS DESCRIPTION	PRINCIPAL DX CODE
0606300603	1071035	Agrawal,Rekha	03/05/2006	03/06/2006	Syncope and Collapse	780.2
0606501680	743824	Tighe,Michael	03/06/2006	03/07/2006	Angina Pectoris	413.9
0608600914	798092	Murdock,Alfred	03/27/2006	03/28/2006	Cardiac Dysrthmias	427.89
0610200053	251701	Krell,Mark	04/12/2006	04/12/2006	Cardiac Dysrthmias NOS	427.9
0610401883	617828	May-Ortiz,Jennifer	04/15/2006	04/15/2006	Delirium DT Other Conditions	293.0
0610600165	74317	Goodluck,Pramodchandra	04/16/2006	04/17/2006	Syncope and Collapse	780.2
0611900277	1013640	Rubenstein,Stephen	04/29/2006	04/30/2006	Hyposmolality	276.1
0613000278	576549	Sales,Clifford	05/10/2006	05/11/2006	Ath Ext NTV at w RST PN	440.22
0613602073	625063	Schreck,David	05/16/2006	05/18/2006	Syncope and Collapse	780.2
0615002353	807625	Naik,Arun C	05/31/2006	06/01/2006	Chest Pain	786.50
0615602133	574484	Hakim,James	06/05/2006	06/06/2006	Heart Disease	429.9
0614700349	239791	Jackson,Thomas	05/27/2006	05/28/2006	Chest Pain	786.50
0627201294	1089476	Das,Mohan	09/30/2006	09/30/2006	Dizziness and Giddiness	780.4
0629301880	544291	Alterman,Lloyd	10/20/2006	10/21/2006	Renal Failure	586
0630702035	1087413	Das,Mohan	11/03/2006	11/04/2006	Syncope and Collapse	780.2
0636500525	953630	Piliscia, Thomas	01/01/2007	01/01/2007	Syncope and Collapse	780.2
0700400061	402533	Gianis, Thomas J	01/04/2007	01/05/2007	Renal Colic	788.0
0700902453	1047887	Lehrhoff,Bernard	01/09/2007	01/10/2007	Renal Colic	788.0
0703100872	1092636	Bhatnagar,Vineesh	01/31/2007	02/03/2007	GI Hemorrhage NOS	578.9
0704701685	768921	Patel,Samir	02/16/2007	02/17/2007	Dizziness and Giddiness	780.4
0708501585	342118	Shapiro, Jason	03/26/2007	03/29/2007	Syncope and Collapse	780.2
0709500300	1034593	Tabachnick, John F.	04/05/2007	04/05/2007	Syncope and Collapse	780.2
0709400002	720878	Abraham, Vinod J.	04/04/2007	04/07/2007	Anemia NOS	285.9
0707500903	1103009	Sheris,Steven J.	03/21/2007	03/21/2007	Cor Ath Unsp Vsl Ntv/Gft	414.00
0709901944	553758	Gutierrez,Evangeline R.	04/09/2007	04/13/2007	Crbl Art Occl NOS c Infrc	434.91
0710200668	782523	Dhupar,Shawn	04/12/2007	04/13/2007	Cardiac Dysrhythmias	427.89
0710102006	1034593	Wagner,Claudia	04/11/2007	04/14/2007	Cardiac Dysrhythmias	427.89
0710200900	551833	Alterman,Lloyd	04/12/2007	04/14/2007	Renal Failure NOS	586
0710802084	1056493	Patel,Samir	04/19/2007	04/20/2007	Altered Mental Status	780.97
0711300734	945369	Bhansali,Neha	04/23/2007	04/25/2007	Encephalopathy NOS	348.3
0711402236	726256	Schreck,David	04/24/2007	04/26/2007	Syncope and Collapse	780.2
0712500624	777215	Dhupar,Shawn	05/05/2007	05/06/2007	Abn Clinical Finding NEC	796.4
0712402140	688421	Gutierrez,Evangeline R.	05/05/2007	05/07/2007	Chest Pain	786.50
0712700712	832174	Alterman,Lloyd	05/07/2007	05/10/2007	End Stage Renal Disease	585.6
0712802171	1107757	Shapiro, Jason	05/08/2007	05/10/2007	Pneumonia	486
0713402274	1108293	Freeman,Barry C.	05/14/2007	05/19/2007	Fracture NOS - closed	829.0
0713800051	596775	Meisner,Errol C.	05/18/2007	05/20/2007	Dizziness and Giddiness	780.4
0714600477	615983	Abraham, Vinod J.	05/27/2007	05/29/2007	Cervicalgia	723.1
0712302127	726125	Sheris,Steven J.	06/05/2007	06/05/2007	Chr Ischemic Hrt Dis NEC	414.8
0715701725	532977	Abraham, Vinod J.	06/06/2007	06/07/2007	Atrial Fib	427.31
0716500031	753532	Gelber, Charles M.	06/14/2007	06/15/2007	Resp Abnormality NEC	786.09
0716700473	927030	Dhupar,Shawn	06/16/2007	06/18/2007	End Stage Renal Disease	585.6
0715300494	1109889	Morandi,Michele	06/03/2007	06/30/2007	Cardiac Dysrhythmias NEC	427.89
0716601913	1102585	Caggia,Josephine	06/15/2007	06/19/2007	Psychosis NOS	298.9
0717201568	856121	Wax,Michael B.	06/21/2007	06/25/2007	Malign Neopl Thyroid	193.0
0717702056	609979	Gutierrez,Evangeline R.	06/26/2007	06/27/2007	Venous Thrombosis NEC	453.8
0717802054	620935	Shapiro, Jason	06/28/2007	06/29/2007	Circulatory Disease NOS	459.9
0718100440	1085016	Dhupar,Shawn	06/30/2007	07/01/2007	Infect/Parasite Dis NOS	136.9
0716601317	788019	Harjani,Vashdeo	06/15/2007	06/16/2007	Cardiac Dysrhythmias NEC	427.89
0719000064	1079811	Gutierrez,Evangeline R.	07/09/2007	07/10/2007	CHF	428.0
0719000104	600916	Alterman,Lloyd	07/09/2007	07/10/2007	End Stage Renal Disease	585.6
0720200548	643357	Morandi,Michele	07/21/2007	07/23/2007	Venous Thrombosis NEC	453.8
0720100200	901227	Salvatore,August G.	07/20/2007	07/21/2007	Trans Cereb Ischemia NOS	435.9
0720700794	771133	Ali,Nadia	07/26/2007	07/27/2007	Malaise and Fatigue NEC	780.79
0720801723	655592	Patel,Samir	07/27/2007	07/28/2007	Noninflam Dis Vagina NEC	623.8
0721402172	1114929	Naik,Arun C	08/02/2007	08/03/2007	Chest Pain	786.50

0722201921	1036459	Gutierrez,Evangeline R.	08/10/2007	08/12/2007	Syncope and Collapse	780.2
0722200763	1011136	Shapiro, Jason	08/10/2007	08/11/2007	Crbl Art Occ NOS w Infrc	434.91
0720800526	559718	Kumar,Mark H.	08/13/2007	08/14/2007	Cmp Int Orth Dev/Grft NOS	996.40
0723000407	474443	Rubenstein,Stephen	08/18/2007	08/22/2007	Gastrointestinal Hemorrhage	578.9
0723000331	812839	Solomon,Robert B.	08/18/2007	08/19/2007	Chest Pain	786.50
0723800486	1116855	Solomon,Robert B.	08/27/2007	08/28/2007	Joint Pain-Pelvis	719.45
0724201964	827207	Subramanian,Gomathy	08/30/2007	08/31/2007	NonPsychoticBrain Syn	310.9
0724301357	572472	Nastro,Lawrence J.	08/31/2007	09/05/2007	Syncope and Collapse	780.2
0724900259	777215	Dhupar,Shawn	09/06/2007	09/06/2007	Anemia NOS	285.9
0725001967	622056	Subramanian,Gomathy	09/08/2007	09/08/2007	End Stage Renal Disease	585.6
0724901473	511947	Gutierrez,Evangeline R.	09/06/2007	09/07/2007	Fx Foot Bone NOS - Closed	825.20
0725200033	396161	Mich,Robert J.	09/09/2007	09/09/2007	AMI NOS, Unspecified	410.90
0725100594	463427	Rubenstein,Stephen	09/08/2007	09/09/2007	Dizziness and Giddiness	780.4
0725201963	1062461	Morandi,Michele	09/19/2007	09/20/2007	Hyperpotassemia	276.7
0726101858	1063020	Zampella,Edward J.	09/18/2007	09/20/2007	Neuralgia/Neuritis NOS	729.2
0726301369	1119007	Greenman,James L.	09/20/2007	09/24/2007	Backache NOS	724.5
0726301108	501333	Subramanian,Gomathy	09/20/2007	09/22/2007	Syncope and Collapse	780.2
0724300670	1117324	Agrawal,Rekha	08/31/2007	09/04/2007	Dehydration	276.51
0727900656	1120834	Harjani,Vashdeo	10/07/2007	10/08/2007	Chest Pain	786.50
0730301552	1066587	Dalena, Dorothy	10/30/2007	10/30/2007	Syncope and Collapse	780.2
0731800072	526608	Gelber, Charles M.	11/14/2007	11/16/2007	Dizziness and Giddiness	780.4
0733000072	671816	Prasad,Sanjiv	11/26/2007	11/27/2007	Heart Disease NOS	429.9
0732000979	734035	Starker,Paul	11/20/2007	11/21/2007	Cholelith w Cholecys NEC	574.10
0733505340	374460	Jackson,Thomas	12/01/2007	12/02/2007	Skin Sensation Disturb	782.0
0734400134	603487	Profeta,Susan B.	12/10/2007	12/11/2007	Gastrointestinal Hemorr NOS	578.9
0732402075	457283	Schreck,David	12/11/2007	12/13/2007	Shortness of Breathe	786.05
0735600334	684740	Rubenstein,Stephen	12/22/2007	12/23/2007	Syncope and Collapse	780.2
0734900561	674017	Fuhrman, Michael A.	12/21/2007	12/22/2007	Hemorrhage NOS	459.0
0736202014	686960	Mendiola,Redentor S.	12/28/2007	12/29/2007	Chest Pain NOS	786.50
0730400007	536155	Cantor,Jerome	01/04/2008	01/07/2008	Vomiting Alone	787.03
0730800911	1095770	Alla,Nivedita	01/08/2008	01/09/2008	Joint Pain-Pelvis	719.45
0736102231	1130316	Subramanian,Gomathy	12/28/2007	12/28/2007	Venous Thrombosis NEC	453.8
0730702515	393108	Nastro,Lawrence J.	01/07/2008	01/11/2008	CHF NOS	428.0
0731001881	1045134	Subramanian,Gomathy	01/10/2008	01/15/2008	Backache NOS	724.5

Other Specific Examples of Improper Admissions at Overlook Hospital

102. **Overlook Hospital Emergency Department ("ED") Transfer to Manor Care Event. Patient number: B01120108. Overlook Hospital admit date: 10/2/07.** This is a case of an observation discharge to Manor Care (an SNF), where the facility tried to return the patient to Overlook Hospital to get her admitted for three overnights when there was no medical necessity for doing so. The patient was treated at the ED following a traumatic pelvic and wrist fracture. She did not require observation nor did she require inpatient admission and was transferred to Manor Care as a direct transfer from the ED. The director physician of the SNF who was caring for the patient, Dr Ippilito, provided false medical information about the patient to Overlook Hospital in an attempt to get the patient passed though admission screening. Specifically, he falsely related that the patient had intractable pain, needed therapy and could not move. He also falsely reported that there was an infection/phlebitis of the lower extremity and the patient needed IV antibiotic for this. Dr. Ippilito was reported to the alterative care facility and to Overlook Hospital for this activity.

103. **ID: 0801001881 Dr Subramanian Admit 1/10/08.** This patient was originally classified as observation for back pain (diagnosis spinal stenosis) and constipation. Dr. Subramanian converted this patient to inpatient status even though admission criteria were not met. The hospital subsequently placed this patient on the Part B inpatient list (code 121) and transferred him to Acute Rehab for back pain. The acute care Part A benefit was utilized to cover his acute rehab admission to RIMM without requiring the three consecutive overnights that would have qualified him under the subacute benefit.

104. **ID: 0802801088, Dr Schreck admit 1/28/08.** Admission for suspected sepsis (infection) and pneumonia. This patient was found in her home two days after passing out. She was a chronically ill patient with cancer and treated empirically for suspected infection and dehydration. Clinical and labs did not support severe enough illness to be considered an acute inpatient. The chest Xray findings were not accurately related and did not show pneumonia. In an attempt to artificially support a finding of pneumonia (as opposed to chronic changes), Dr. Schreck ordered IV antibiotic to be given but infection was never ruled in since cultures were negative. These steps were taken solely to meet the financial needs of the patient's family who were looking from the outset family for long term care placement. Dr. Schreck openly refused to convert this patient to observation and focused on ensuring she had a three day stay. Immediately after the three day standard was met, Dr. Schreck discharged this patient to subacute rehab. This patient did not meet the criteria for subacute rehabilitation and should have been placed in a nursing home for custodial care.

105. **ID B01133106 Dr Schulman Admitted to inpatient originally on 1/21/07** Patient's status changed to observation level of care via code 44 upon case management intervention. This patient was discharged after a four day length of stay (LOS). The patient was diagnosed with senile Parkinson's disease (falls, dementia, senility). The attending physician's notes from the day on inpatient admission candidly acknowledge that, "subacute rehab placement at Cornell Hall." In other words, it was the physician's plan from day one, even before a rehab evaluation was done, to get this senile patient, who was not functioning at home, into rehab and then to long term care in a nursing home under a Medicare

benefit based on an acute inpatient admission. The UR department at Overlook Hospital identified and stopped this from happening on this one occasion.

106. **B01136633 admit 2/18/08** urinary tract infection, mild dehydration, admit criteria not met, senile patient unable to be cared for at home social disposition. Dr Steven Eisenstat.

107. **0713402274 admit 5/14/07; discharged 5/19/07.** Dr Barry Freeman admitted the patient at the acute inpatient level of care. The patient was cared for at home with assistance, was recently discharged from another acute care facility having been managed for a lumbar compression fracture. She suffered from back pain and was in need of pain management and supportive care. Oral pain medication and transdermal pain medication were initially ordered. There was a request by the family for rehab transfer the day of admission. The physician allowed the patient to be changed to observation status upon request of the physician advisor and ordered on 5/15/07. The patient did not have a Medicare benefit for subacute rehabilitation services once under outpatient observation and the following day, 5/16/07, Dr. Freeman ordered the patient to to be changed back to acute inpatient level of care and may have ordered a blood transfusion unnecessarily in order to help to justify the upgrade in level of care. This was reported to the quality department immediately.

On May 18, 2007, Dr. Freeman wrote a physician order to transfer the patient to Genesis Westfield, the facility to which he admits. This type of steering of patients is not permitted under the Medicare program, however, periodically occurs at Overlook. There were no open beds available at Genesis over that weekend. In addition, the three overnight stay requirement was not formally met due to the initial observation day. Criteria for acute inpatient level of care was never met but the physician would not maintain the patient on observation or

manage the care within the recommended timeframe of 23 to 48 hours. The lack of benefit and availability of a bed led the patient to be discharged to home on May 19, 2007. The physician's plan appeared to have the patient admitted into a rehab facility at the outset. The Director of Medical Affairs, Dr. Norman Luka, and Dr. John Doe discussed this particular case with Dr Barry Freeman. Concerns were raised with Dr Freeman regarding quality of care and utilization and documentation on this case.

Patients were routinely admitted and maintained at the acute inpatient level of care for the required three day stay in order to qualify them for a subacute rehab benefits prior to their rehab transfer. Many are ultimately transitioned into long term care for ongoing supportive and custodial care needs.

108. **ID 0804602119** Length of say **3** days inpatient **admission 2/16/08 discharged 2/19/08**. Observation case admitted as acute inpatient for syncope, fall and could not get up, treated for urinary tract infection and compression fracture, oral medications, consultation, cardiac monitoring. No acute interventions or clinical progression or ongoing acute care services and did not meet inpatient criteria. Dr Mohan Das, the attending physician, refused to convert the patient to observation under code 44 when requested to do so by the case manager on the unit after she had discussed the case with me yesterday and lacking any acute changes in the patient's care today. Since the patient had already been discharged and left by the time I called Dr Das today, the case had to be placed onto Part B Code 121. Dr Das is not familiar with InterQual criteria and was unaware that the patient had been discharged and had left the facility when I spoke to him regarding my concerns about his behavior and level of care assigned to this patient. The discharge was actually coordinated by the specialty consultant.

109. **B00793990 admit 2/16/08; DC 2/1708.** Admitted to Dr. Nadia Ali She is a hospitalist who admitted as inpatient for vertigo coded as Dizziness and Giddiness. Treated with oral antivert for the dizziness and discharged the following day. Ordered admission (which here is considered synonymous for acute inpatient) and we opted to place the case as part B inpatient... code 121 and not bill part A. As crystal clear as a case can be.

110. **ID:** 0805002383 admit 2/19/08. Admitted by Dr. Zampella, head of the neurosurgical group; cleared for admission by Dr. Brensilver, chief of medicine, after medical consultation. Patient (95) admitted preoperatively for laminectomy with known, planned surgery for spinal stenosis. Symptoms "back pain." Unnecessary preoperative night and one or more days of unnecessary acute care. Should have been same day surgical admission.

CAUSES OF ACTION

FIRST CAUSE OF ACTION
(Federal False Claims Act Violations--31 U.S.C. § 3729(a)(1))
Submission of False and Fraudulent Claims

111. Relators repeat and reallege by reference paragraphs 1 through 110 above as if fully set forth herein.

112. In connection with claims for Medicare funds, from at least as early as 2002 to at least as late as the date of this complaint, Defendants engaged in a continuous practice of knowingly presenting, and causing to be presented, to a CMS officer or employee false and fraudulent claims for payment or approval, in violation of the Federal False Claims Act, § 31 U.S.C. §3729(a)(1).

113. The federal Government paid funds to Defendant upon the false and fraudulent claims described in this complaint and has thereby suffered damages.

114. Had the federal Government known of the falsity or fraudulent nature of the Defendants' claims, it would not have paid funds to them.

SECOND CAUSE OF ACTION

(Federal False Claims Act Violations--31 U.S.C. § 3729(a)(2))
Making, using, and causing to be made and used, false records and statements

115. Relators repeat and reallege by reference paragraphs 1 through 110 above as if fully set forth herein.

116. In connection with claims for Medicare funds, from at least as early as 2002 to at least as late as the date of this complaint, Defendants engaged in a continuous practice of knowingly making, using, and causing to be made and used, false records and statements to get false or fraudulent claims paid and approved by CMS, in violation of in violation of the Federal False Claims Act, § 31 U.S.C. §3729(a)(2).

117. The federal Government paid funds to Defendants based upon the false records and statements that it made and used to get false claims paid or approved by Medicare, as described in this complaint, and has thereby suffered damages.

118. Had the federal Government known of the falsity of the Defendants' records and statements, it would not have paid funds to them.

THIRD CAUSE OF ACTION

(Federal False Claims Act Violation-- 31 U.S.C. § 3729(a)(3))
Conspiracy

119. Relators repeat and reallege by reference paragraphs 1 through 110 above as if fully set forth herein.

120. In connection with claims for Medicare funds, from at least as early as 2002 to at least as late as the date of this complaint, Defendants conspired to defraud CMS by getting false and fraudulent claims allowed and paid, in violation of in violation of the Federal False Claims Act, § 31 U.S.C. §3729(a)(3).

121. The federal Government suffered economic damages as a result of Defendants' conspiracy.

PRAYER FOR RELIEF

WHEREFOR, Relators, on behalf of themselves individually, and on behalf, and in the name, of the Government of the United States, demands and prays that judgment be entered against the Defendants as follows:

A. Ordering Defendants to cease and desist from violating the False Claims Act, 31 U.S.C. §§ 3729-3733.

B. On the First, Second and Third Causes of Action against Defendants damages in the amount of three times the amount of loss the United States has sustained because of Defendants' actions, plus a civil penalty of $11,000 for each act in violation of the False Claims Act, as provided by 31 U.S.C. § 3729(a), with interest.

C. Awarding Relator the maximum amount available under the False Claims Act, 31 U.S.C. § 3730(d) for bringing the First, Second and Third Causes of Action, namely, 25 percent of the proceeds of the action by judgment or settlement of the claim if the Government

intervenes in the matter (or pursues its claim through any alternate remedy available to the Government, 31 U.S.C. § 3730(c)(5)), or, alternatively, 30 percent of the proceeds of the action by judgment or settlement of the claim, if the Government declines to intervene.

D. As to First, Second and Third Causes of Action in this complaint, awarding Relators all reasonable expenses that were necessarily incurred in prosecution of this action, plus all reasonable attorneys' fees and costs, as provided by 31 U.S.C. §§ 3730(d). And,

E. For such other relief for the United States and Relators as this Court deems just and proper.

DEMAND FOR JURY TRIAL

Relator hereby demands trial by jury.

Dated: River Edge, New Jersey
April 25, 2008

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