GEOFFREY S. BERMAN
United States Attorney
Southern District of New York
By: MÒNICA P. FOLCH
JACOB M. BERGMAN
Assistant United States Attorneys
86 Chambers Street, 3rd Fl.
New York, NY 10007
Tel.: (212) 637-6559/2776
Email: monica.folch@usdoj.gov
jacob.bergman@usdoj.gov

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA and STATE OF NEW YORK *ex rel.* CAROL BEVILACQUA, Plaintiffs, v. CITY PRACTICE GROUP OF NEW YORK, LLC, *et al.*, Defendants.	**COMPLAINT-IN-INTERVENTION OF THE UNITED STATES OF AMERICA** 14 Civ. 9933 (KPF)
UNITED STATES OF AMERICA, Plaintiff-Intervenor, v. CITY PRACTICE GROUP USA, LLC, Defendant.	14 Civ. 9933 (KPF)

The United States of America, by its attorney, Geoffrey S. Berman, United States Attorney for the Southern District of New York, alleges for its complaint-in-intervention as follows:

PRELIMINARY STATEMENT

1. This is a civil fraud action brought by the United States of America (the "United States" or the "Government") against City Practice Group USA, LLC ("CityMD" or Defendant), under the False Claims Act (the "FCA"), 31 U.S.C. §§ 3729-3733, to recover treble damages sustained by, and civil penalties owed to, the Government resulting from the submission of false and fraudulent claims for reimbursements to the Medicare Program, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.* ("Medicare"),

2. CityMD manages and operates approximately 88 urgent care medical offices primarily located in and around New York City. As set forth more fully below, from 2010 through December 31, 2016, CityMD engaged in two separate fraudulent schemes, each resulting in the submission to Medicare of false and fraudulent claims for reimbursements.

3. In the first scheme, CityMD submitted or caused the submission of claims to Medicare for services rendered using the name and National Provider Identification number ("NPI") of physicians who did not perform or supervise the medical services claimed. The physicians who actually performed or supervised the services were not credentialed at CityMD. Medicare rules prohibit urgent care centers like those operated by CityMD from billing for services rendered by non-credentialed physicians. Therefore, Medicare would not have paid these claims if they had been submitted to Medicare using the NPIs of non-credentialed physicians. To get around this rule, CityMD submitted the claims to Medicare using the NPI number of credentialed physicians who did not perform or supervise the services claimed.

4. In the second scheme, CityMD submitted or caused the submission of claims to Medicare for evaluation and management ("E/M") services using Current Procedural Terminology ("CPT") billing codes reflecting lengthier and/or more complex services than were

actually provided to patients. Had CityMD billed the appropriate CPT codes, it would have received a lower rate of reimbursement from Medicare.

JURISDICTION AND VENUE

5. This Court has jurisdiction over the claims brought under the False Claims Act pursuant to 31 U.S.C. § 3730(a) and 28 U.S.C. §§ 1331 and 1345.

6. Venue lies in this District pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. §§ 1391(b) and 1391(c) because Defendant transacts business in this district.

PARTIES

7. Plaintiff is the United States of America suing on its own behalf and on behalf of the United States Department of Health and Human Services ("HHS"), and its component agency, CMS, which administers the Medicare Program.

8. Defendant City Practice Group USA, LLC, which does business as CityMD, manages and operates approximately 88 urgent care professional practice affiliate offices, the majority of which are located in the New York City metropolitan area. CityMD is located at 2146 Bartow Avenue, Bronx, NY 10475.

FACTS

A. The Medicare Program

9. In 1965, Congress enacted Title XVIII of the Social Security Act, known as the Medicare program, to pay for the costs of certain healthcare services. Entitlement to Medicare is based on age, disability or affliction with end-stage renal disease. *See* 42 U.S.C. §§ 426, 426A.

10. Medicare has several parts, including Part B, which is primarily for physician and other ancillary services. Claims for Medicare Part B services are submitted on CMS form 1500.

11. The CMS 1500 form requires the physician who signs the form to represent that:

"[i]n submitting this claim for payment from federal funds, I certify that: ... the services on this form were ... personally furnished by me." Under the line, "Signature of Physician (or Supplier)," the individual is also directed to represent: "I certify that the services listed above ... were personally furnished by me." In the Medicare Program Integrity Manual, CMS lists as an example of Medicare fraud, misrepresenting the identity of the individual who furnished the services. *See* Medicare Program Integrity Manual, Ex 27, Section 4.2.1, Rev. 675, effective 12-12-16.

12. Further, Medicare prohibits payment for services that are not "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." 42 U.S.C. § 1395y (a)(l)(A). For most services, a reasonable charge has been defined as the lowest of (a) the actual billed charge, (b) the provider's customary charge, or (c) the prevailing charge for the service in the locality. 42 C.F.R. §§ 405.502-504.

13. For all codes, the medically necessary E/M service and the procedure must be documented sufficiently by the physician or qualified non-physician practitioner in the patient's medical record to support any claim submitted to Medicare for the service and/or procedure. Medicare Claims Processing Manual, Chap. 12 at § 30.6.6(B), Rev. 3873, 10-6-17.

14. As with misrepresenting the identity of the individual who furnished the services, CMS also lists as an example of Medicare fraud, incorrect reporting of procedures to maximize payments. *See* Medicare Program Integrity Manual, Ex 27, Section 4.2.1, Rev. 750, 10-20-17.

B. National Provider Identification Numbers and Credentialing

15. The NPI is a unique 10-digit identification number for healthcare providers that is used by all health plans, including Medicare, in the submission of claims for reimbursement. All healthcare providers are eligible to receive an NPI. All Health Insurance Portability and

Accountability Act ("HIPAA") covered healthcare providers, whether they are individuals (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or organizations (such as hospitals and clinics, group practices, etc.) must obtain an NPI in order to identify themselves in HIPAA standard transactions, such as Medicare claim submissions.

16. Physicians, along with all Medicare Part B providers, must enroll in the Medicare program in order to be paid for services rendered to Medicare recipients. If that physician joins a practice group like CityMD, he or she must also file a "Reassignment of Medicare Benefits" application (Form CMS-855R) before that practice group can receive payments for services rendered by that physician. *See* Medicare Enrollment for Physicians, NPPs, and Other Part B Suppliers, MLN (Medicare Learning Network) Booklet, Dec. 2017 *found at* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PhysOther_FactSheet_ICN903768.pdf.

17. Medicare rules prohibit Medicare Part B providers from seeking reimbursement from the Medicare program for services rendered by a physician unless that physician is both enrolled with the Medicare program when the services are rendered and has reassigned his or her Medicare benefits to the billing provider (collectively known as being "credentialed" with the Medicare program). *See, e.g.,* 42 C.F.R. § 424.5(a)(2).

C. CPT Codes

18. In order to receive reimbursement payments from the Government for medical services covered by Medicare, a provider must submit claims for payment containing CPT codes. These codes are a set of standardized medical codes developed and maintained by the American Medical Association. CPT codes are used to describe and report medical, surgical and diagnostic procedures and services to public and private health insurance programs for medical billing

purposes.

19. The United States uses CPT codes to determine both coverage, *i.e.*, if it will pay for the billed medical procedures and services, and reimbursement, *i.e.*, how much it will pay for the billed medical procedures and services.

20. Each procedure or service or item furnished to a patient has a specific CPT code. Further, each CPT code receives a certain level of reimbursement, which may vary depending on what other codes are simultaneously submitted. The amount of money a physician is paid by Medicare for a service rendered to a patient depends on which CPT codes are submitted as part of the corresponding claim.

21. As directed by the American Medical Association, in addition to CPT codes used to bill for a procedure, service, or item, certain CPT codes (specifically 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215) are used to indicate various degrees of E/M of patients when they make an in-office visit for treatment at an urgent care center.

22. These E/M CPT codes differ depending on whether the patient is a new or established patient, the amount of time the physician spends with the patient, the types of services the physician renders, and the complexity of the case. As the amount of time the physician spends and the breadth of the services the physician renders increase, the E/M CPT code that the physician may select increases. E/M CPT codes 99201 and 99211 are the lowest-level codes for new and established patients, respectively. E/M CPT codes 99205 and 99215 are the highest-level codes for new and established patients, respectively. More specially, the AMA provides that:

> (a) Codes 99201 and 99211 are to be used for patients whose problem(s) are "minor" or "minimal," with physicians typically spending 10 minutes with the new patients and 5 minutes with established patients.

(b) Codes 99202 and 99212 are to be used for patients whose problem(s) are low to moderate, with physicians typically spending 20 minutes with the new patients and 10 minutes with established patients.

(c) Codes 99203 and 99213 are to be used for patients whose problem(s) are moderate to severe, with physicians typically spending 30 minutes with the new patients and 15 minutes with established patients.

(d) Codes 99204 and 99214 are to be used for patients whose problem(s) are moderate to highly severe, with physicians typically spending 45 minutes with the new patients and 25 minutes with established patients.

(e) Codes 99205 and 99215 are to be used for patients whose problem(s) are moderate to highly severe, with physicians typically spending 60 minutes with the new patients and 40 minutes with established patients.

23. With regard to Codes 99204 and 99214 specifically, the AMA further provides that documentation for such patient encounters must include information reflecting at least two of the following: (1) a detailed history of the patient's health; (2) a detailed exam of the patient; or (3) moderate complexity medical decision-making.

D. False Claims Act

24. The FCA establishes liability to the United States for any person who "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," 31 U.S.C. § 3729(a)(1), or "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim," § 3729(a)(1)(B). "Knowingly" is defined to include actual knowledge, reckless disregard, and deliberate indifference. *Id.* § 3729(b). No proof of specific intent to defraud is required. *Id.*

I. Defendants' Fraudulent Conduct

A. CityMD Billed Medicare Using the NPIs of Physicians Who Did Not Perform the Services Claimed

25. From 2010 through 2015, CityMD employed a number of physicians who were

not credentialed with the Medicare program as of the date the claims were submitted. Medicare rules prohibit CityMD from billing Medicare for any services performed or supervised by these non-credentialed physicians until such physicians are credentialed with the Medicare program.

26. Nevertheless, CityMD falsely billed Medicare for services rendered by physicians not then-credentialed. CityMD concealed its violation of Medicare rules prohibiting this practice by billing for the services using the NPIs of credentialed physicians who did not actually perform or supervise the services in question.

27. Had Medicare known that the physicians whose NPIs were used to bill Medicare did not render or supervise the services in question or that the physicians who actually rendered the services were not credentialed, Medicare would not have paid these claims.

28. For example, on December 23, 2010, Dr. M, who was employed at a CityMD urgent care center but not credentialed with the Medicare program, gave patient A a rapid influenza test. However, CityMD billed Medicare for this test under the NPI of Dr. X, who also was employed at CityMD and was credentialed as of the date of the procedure. Had Medicare known that Dr. X was not the actual rendering physician, it would not have paid this claim.

29. Similarly, on July 1, 2013, Dr. N, who was employed at a CityMD urgent care center but not credentialed with the Medicare program, treated patient B for a urinary tract infection. However, CityMD billed Medicare for this service under the NPI of Dr. Y, who also was employed at CityMD and was credentialed as of the date of the procedure. Had Medicare known that Dr. Y was not the actual rendering physician, it would not have paid this claim.

30. Likewise, on September 25, 2014, Dr. O, who was employed at a CityMD urgent care center but not credentialed with the Medicare program, treated patient C for fatigue. However, CityMD billed Medicare for this service under the NPI of Dr. Z, who also was

employed at CityMD and was credentialed as of the date of the procedure. Had Medicare known that Dr. Z was not the actual rendering physician, it would not have paid this claim.

B. CityMD Billed Medicare for More Expensive E/M Services Than It Actually Rendered

31. Between 2010 and 2016, CityMD submitted tens of thousands of claims to the Medicare program for services using CPT billing codes reflecting lengthier and/or more complex E/M services or procedures than it actually provided to patients. The patients for whom CityMD billed these services often presented with simple, non-severe conditions, such as a cough, nasal congestion, or post-nasal drip. Such conditions—without additional, more severe health conditions—are typically minor health issues that do not require complex medical treatment or analysis. Nevertheless, CityMD routinely submitted claims to Medicare using CPT codes 99204 and 99214 for treatment of new and established patients presenting with minor health issues, despite the fact that these codes are reserved for patients that present with moderate to highly severe problems that require more complex medical analysis and treatment.

32. For instance, on June 6, 2012, CityMD billed Medicare for Patient E using code 99204. The sole diagnosis associated with Patient E was a "cough." Alone, a cough virtually never requires an encounter with the length and/or complexity necessary to use code 99204, which should "be used for patients whose problem(s) are moderate to highly severe, with physicians typically spending 45 minutes with the new patients." Medicare would not have reimbursed CityMD for this service had it known the true length and/or complexity of this encounter.

33. Likewise, on November 16, 2014, CityMD billed Medicare for Patient F using code 99204. However, the sole diagnosis associated with Patient F was a "postnasal drip." A postnasal drip—without an accompanying more severe health condition—virtually never

requires an encounter with the length and/or complexity necessary to use code 99204, as it is not a "moderate to highly severe" health problem requiring a 45-minute examination. Medicare would not have reimbursed CityMD for this service had it known the true length and/or complexity of this encounter.

34. Further, on December 6, 2016, CityMD billed Medicare for Patient G using code 99204. However, the sole diagnosis associated with Patient G was an "unspecified sprain of the right little finger," which alone does not constitute a "moderate to highly severe" health problem requiring an encounter with the length and/or complexity necessary to use code 99204. Medicare would not have reimbursed CityMD for this service had it known the true length and/or complexity of this encounter.

CLAIM FOR RELIEF

FIRST CLAIM

Violation of the False Claims Act: Presenting False Claims for Payment (31 U.S.C. § 3729(a)(1)(A))

35. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

36. The Government seeks relief against CityMD under Section 3729(a)(1)(A) of the False Claims Act.

37. As a result of billing for medical services using the NPIs of physicians who did not perform the services, CityMD knowingly caused false claims to be presented for reimbursement by Medicare, in violation of 31 U.S.C. § 3729(a)(1)(A).

38. By reason of these false or fraudulent claims that CityMD caused to be presented to Medicare, the United States has paid substantial Medicare reimbursements to CityMD, and is entitled to recover treble damages plus a civil monetary penalty for each false claim.

SECOND CLAIM

Violation of the False Claims Act: Presenting False Claims for Payment (31 U.S.C. § 3729(a)(1)(A))

39. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

40. The Government seeks relief against CityMD under Section 3729(a)(1)(A) of the False Claims Act.

41. By inflating the amount of the value of services provided to Medicare beneficiaries by billing for more expensive E/M Services than were actually rendered, CityMD knowingly caused false claims to be presented to Medicare in violation of 31 U.S.C. § 3729(a)(1)(A)

42. By reason of these false or fraudulent claims that CityMD caused to be presented to Medicare, the United States has paid substantial Medicare reimbursements to CityMD, and is entitled to recover treble damages plus a civil monetary penalty for each false claim.

THIRD CLAIM

Violation of the False Claims Act: Use of False Statements (31 U.S.C. § 3729(a)(1)(B))

43. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

44. The Government seeks relief against CityMD under Section 3729(a)(1)(B) of the False Claims Act.

45. As a result of billing for medical services using the NPIs of physicians who did not perform the services, CityMD knowingly caused false records or statements to be made that

were material to getting false or fraudulent claims paid by Medicare, in violation of 31 U.S.C. § 3729(a)(1)(B).

46. By reason of these false or fraudulent records or statements that CityMD caused to made, the United States has paid substantial Medicare reimbursements to CityMD, and is entitled to recover treble damages plus a civil monetary penalty for each false claim.

FOURTH CLAIM

Violation of the False Claims Act: Use of False Statements (31 U.S.C. § 3729(a)(1)(B))

47. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

48. The Government seeks relief against CityMD under Section 3729(a)(1)(B) of the False Claims Act.

49. By inflating the value of services provided to Medicare beneficiaries by billing for more expensive E/M services than were actually rendered, CityMD knowingly caused false records or statements to be made that were material to getting false or fraudulent claims paid by Medicare in violation of 31 U.S.C. § 3729(a)(1)(B).

50. By reason of these false or fraudulent records or statements that CityMD caused to be made, the United States has paid substantial Medicare reimbursements to CityMD, and is entitled to recover treble damages plus a civil monetary penalty for each false claim.

PRAYER FOR RELIEF

WHEREFORE, the United States demands judgment against the defendant as follows:

A. A sum equal to treble the United States' damages and civil penalties to the maximum amount allowed by law;

B. Award of costs pursuant to 31 U.S.C. § 3792(a)(3); and

C. Such further relief as is proper.

Dated: New York, New York
May 2, 2018

Respectfully submitted,

GEOFFREY S. BERMAN
United States Attorney for the
Southern District of New York
Attorney for the United States

By: _____

MONICA P. FOLCH
JACOB M. BERGMAN
Assistant United States Attorneys
86 Chambers Street, 3d Floor
New York, NY 10007
Tel.: (212) 637-6559/2776
Fax: (212) 637-2686
Email: monica.folch@usdoj.gov
jacob.bergman@usdoj.gov