IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA ex rel. ROBERT FOX, Administrator of the Estate of Maureen Fox, Deceased, and CATHY GONZALES,	:	
Plaintiffs,	:	**CIVIL ACTION NO. 06-cv-4679**
v.	:	
HOME CARE HOSPICE, INC.; ALEX PUGMAN (a.k.a. ALEKSANDR PUGACHEVSKY); SVETLANA GANETSKY (a.k.a. LANA GANETSKY); MATTHEW KOLODESH (a.k.a. Matvei Kolodech, a.k.a. Michael Kolodech); and MALVINA YAKOBASHVILI,	:	
Defendants.	:	

UNITED STATES' VERIFIED COMPLAINT
PURSUANT TO 31 U.S.C. § 3731(c)

This action involves multi-million-dollar Medicare fraud by a hospice provider and the individuals who operated and controlled it. After discovering and internally reporting the fraud without a satisfactory response, two employee whistleblower-relators initiated the action, one after being fired, and the other after quitting her position in frustration. The case then remained in civil suspense for seven years while the United States criminally investigated and prosecuted the perpetrators.

Now, therefore, the United States having filed a notice of intervention in relators' False Claims Act allegations two years ago, the case being removed from suspense this week, and criminal sentencing of three of the defendants scheduled soon to occur, the United States of America alleges as follows:

I. INTRODUCTION

1. Home Care Hospice, Inc. ("HCH") operated as a Philadelphia-based for-profit hospice provider between 1999 and December 31, 2013. The "relevant period" of such operations, for purposes of this Complaint, was January 1, 2003 through October 30, 2008.

2. During the relevant period, HCH provided hospice services to patients in nursing homes, assisted living facilities, hospitals, and private residences in the Philadelphia area. HCH did not provide any patient care at its Northeast Philadelphia office, which merely served as the hub from which hospice care was managed and coordinated.

3. HCH quickly grew from providing hospice services to 15 patients in 2000 to providing hospice services to over 300 patients by 2006.

4. This action began in October 2006 when two then-former HCH employees -- Maureen Fox (who died in September 2007) and Cathy Gonzales -- sued on behalf of the United States under the *qui tam* provisions of the False Claims Act, 31 U.S.C. § 3730. From December 2005 to June 2006, Ms. Fox had been HCH's Quality Assessment Manager and Director of Performance Improvement and Education. From 2003 to June 2006, Ms. Gonzales had been an HCH field nurse and Assistant Director of Performance Improvement and Education. In June 2006: (a) Ms. Fox and Ms. Gonzales questioned HCH's business practices; (b) HCH then fired Ms. Fox, and Ms. Gonzales quit her HCH employment; and (c) Ms. Fox and Ms. Gonzales then reported their concerns to federal and Commonwealth of Pennsylvania authorities.

5. Based in part on information that relators Fox and Gonzales provided beginning in June 2006, the United States (through the Organized Crime Section of the Federal Bureau of Investigation and the Office of Inspector General of the U.S. Department of Health and Human

Services) carried out an investigation of HCH, with the assistance of Ms. Fox until her death, and with Ms. Gonzales' assistance for several years. To date, the investigation has resulted in several federal criminal guilty pleas and criminal convictions of HCH employees. Because of the long pendency of the criminal investigation and prosecutions, this *qui tam* case was placed on the Court's civil suspense docket from 2006 until this month.

6. The United States brings this False Claims Act action to recover losses sustained by the Medicare Program.[1] Defendants are: (a) HCH; (b) Alex Pugman (also known as Aleksandr Pugachevsky), a registered nurse who was HCH's Director and 50 percent owner; (c) defendant Pugman's wife, Svetlana Ganetsky (also known as Lana Ganetsky), a licensed physical therapist who was HCH's Development Executive; (d) Matthew Kolodesh (also known as Matvei Kolodech and Michael Kolodech), a *de facto* 50 percent owner of HCH who set up, controlled, and operated HCH; and (e) defendant Kolodesh's wife, Malvina Yakobashvili, the nominal Chief Executive Officer, President, and 50 percent owner of HCH.

7. Medicare is a federally funded program that provides medical insurance for certain items and services to qualified persons, including United States citizens who are age 65

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[1] Section 3731(c) of the False Claims Act provides: *"If the Government elects to intervene and proceed with an action brought [under the Act's qui tam provisions by one or more relator(s)], the Government may file its own complaint . . . . For statute of limitations purposes, any such Government pleading shall relate back to the filing date of the complaint of the person who originally brought the action, to the extent that the claim of the Government arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth, in the prior complaint of that person."* Relators' original complaint was filed in October 2006 and sued defendants HCH, Yakobashvili, and Pugman. On October 17, 2011, relators amended their complaint to name, additionally, defendants Kolodesh and Ganetsky. In 2012, defendants Kolodesh and Yakobashvili reached agreement with the United States that *"Any and all statute of limitations and other time-related defenses that are applicable to the United States' claims [against them] shall be tolled beginning on October 16, 2006[.]"* On April 27, 2012, the United States filed its notice of election: (a) to intervene in relators' False Claims Act claims against defendants HCH, Pugman, Ganetsky, and Kolodesh; and (b) to decline to intervene in relators' False Claims Act claims against defendant Yakobashvili. (Relators did not assert any common-law causes of action.)

or older and persons with qualifying disabilities. Medicare is not a free health insurance program. A majority of the Medicare Program's costs are paid by United States citizens through their taxes. In addition to paying for doctor visits, nursing home care, and hospital stays, Medicare pays for what is known as hospice care for eligible Medicare beneficiaries.

8. Hospice companies like HCH are entitled to receive Medicare dollars only for necessary and reasonable hospice services provided to patients who are "terminally ill." An individual is "terminally ill" if he or she has a medical prognosis of six or fewer months to live if the individual's illness runs its normal course. 42 C.F.R. § 418.3. Electing the hospice benefit is a critical decision for an individual because he or she is electing to cease further curative care for his or her illness. Hospice care services include only palliative care, which is care to relieve the pain, symptoms and stress for Medicare beneficiaries who are expected to die within six months.

9. Hospices are paid a per diem rate based on the number of days and level of care provided to the patient. Medicare recognizes and provides reimbursement for four levels of hospice care: (a) routine home care; (b) continuous home care (also known, and referred to throughout this Complaint, as "crisis care"); (c) inpatient respite care; and (d) general inpatient care. The payment rates are based on which level of care the hospice provider furnishes to a patient on a particular day. 42 C.F.R. § 418.302; Medicare Benefit Policy Manual, Chapter 9, § 40.

10. Most hospice care is and should be billed as routine home care. Crisis care -- for which hospice providers receive the highest daily rate of reimbursement -- is available only for patients who are experiencing an acute crisis that requires the immediate and short-term provision of skilled nursing services. By way of example: (a) in fiscal year 2013, Medicare's

reimbursement rate for crisis care was $742 more per patient per day than the daily reimbursement rate for routine home care; (b) in fiscal year 2008, hospice providers in the relevant region were reimbursed by Medicare at the rate of $151 per day for routine home care, and at $882.24 per 24-hour period for crisis care; and (c) during the relevant period, hospice providers were reimbursed by Medicare at a rate of approximately $140 per day for routine home care, and at approximately $800 per 24-hour period for crisis care.

11. HCH was certified to participate in the Medicare Program on June 15, 2000. From January 2003 to October 2008, Medicare reimbursement to HCH for claims submitted for hospice services constituted approximately 91 percent of HCH's total revenue and totaled approximately $49 million.

12. The United States alleges that the defendants focused on maximizing Medicare reimbursement to HCH for as many patients as possible while disregarding Medicare guidelines.

13. Defendants' business and marketing practices led to unnecessary and unreasonable HCH Medicare billings for: (a) routine home care, for patients who were ineligible for the hospice benefit because they were not terminally ill; and (b) costly crisis care services, for HCH patients who did not need, were ineligible for, or, in fact, did not receive crisis care.

14. Between at least January 2003 and October 2008, defendants HCH, Pugman, Ganetsky, and Kolodesh submitted or caused HCH to submit false claims by HCH to the Medicare Program, by both: (a) admitting patients who were ineligible to receive hospice services, because they lacked a life expectancy of six or fewer months to live if their illnesses ran a normal course; and (b) billing Medicare for crisis care services that were far more expensive than routine home care services, when patients did not need crisis care services or when HCH, in

fact, did not provide such services. These four defendants also: (a) submitted or caused to be submitted fraudulent records and statements in support of such false claims for payment to the Medicare Program; and (b) conspired to defraud the United States by getting such false reimbursement claims to the Medicare Program allowed and paid.

15. As a result of this conduct, defendants HCH, Pugman, Ganetsky, and Kolodesh are liable under the False Claims Act ("FCA"), 31 U.S.C. § 3729, et seq. Further, all defendants, including defendant Yakobashvili, were unjustly enriched by this conduct at the expense of the United States and are liable for their unjust enrichment.

Conviction of Defendant Kolodesh

16. On October 17, 2013, a federal jury in the Eastern District of Pennsylvania returned a guilty verdict against defendant Kolodesh, in connection with his control and operation of HCH. The jury found defendant Kolodesh guilty on: (1) one count of conspiracy to commit health care (Medicare) fraud, from on or about January 2003 to December 2008, in violation of 18 U.S.C. § 1349; (2) twenty-one counts of health care fraud, in violation of 18 U.S.C. § 1347; (3) two counts of mail fraud, in violation of 18 U.S.C. § 1341;[2] (4) eleven counts of money laundering, in violation of 18 U.S.C. § 1957; and (5) aiding and abetting, in violation

[2] This included for submission of fraudulent Medicare claims for: (1) Patient J.H., from January 4, 2007 to October 17, 2007; (2) Patient F.D., from March 2, 2007 to December 17, 2007; (3) Patient R.C., from February 29, 2008 to September 5, 2008; (4) Patient T.E., from November 27, 2006 to November 5, 2007; (5) Patient F.G., from June 16, 2006 to August 11, 2008; (6) Patient A.K., from November 3, 2006 to October 18, 2007; (7) Patient P.S., from August 6, 2007 to November 8, 2007, and from April 18, 2008 to May 5, 2008; (8) Patient Y.P., from July 7, 2006 to November 22, 2006, and from February 23, 2007 to November 8, 2007; (9) Patient V.S., from October 12, 2004 to January 11, 2006, and from March 13, 2007 to October 22, 2007; (10) Patient W.W., on July 6, 2007; (11) Patient L.S., on May 20, 2008; (12) Patient N.N., on May 20, 2008; (13) Patient I.K., on August 13, 2008; (14) Patient E.R., on February 23, 2007; (15) Patient E.L., on April 23, 2007; (16) Patient M.M., from March 20, 2007 to May 22, 2007; (17) Patient J.G., from March 19, 2007 to June 5, 2007; (18) Patient R.R., from March 19, 2007 to May 21, 2007; (19) Patient B.H., from March 19, 2007 to December 26, 2007; (20) Patient B.K., from January 4, 2007 to April 19, 2007; and (21) Patient C.B., from April 2, 2007 to May 16, 2007.

of 18 U.S.C. § 2. See United States v. Matthew Kolodesh, No. 11-cr-464 (E.D. Pa.), Dkt. Entry Nos. 100, 101 (Robreno, J.).

17. That felony guilty verdict was based in part on charges in a federal grand jury Indictment that defendant Kolodesh conspired with defendant Pugman and others, in part, to "submit and cause to be submitted [to Medicare] fraudulent health care insurance claims for hospice services purportedly provided by [HCH] in the approximate sum of $14.3 million, when [defendant Kolodesh] knew that the patients were not eligible for hospice services or that the patients did not receive the level of hospice care claimed by [HCH] to have been provided to the patients." See United States v. Matthew Kolodesh, No. 11-cr-464 (E.D. Pa.), Dkt. Entry No. 1.

18. That Indictment further charged that, between January 2003 and October 2008: (a) approximately 30 percent of the patients on HCH routine home care services were ineligible and inappropriate for hospice care, but HCH nevertheless fraudulently obtained payments from Medicare totaling approximately $12,800,000 for these ineligible patients; and (b) of the crisis care level of hospice services that HCH billed for at the higher, more-costly level of approximately $800 per 24-hour period, approximately 90 percent was not provided to HCH patients, but HCH nevertheless fraudulently obtained Medicare payments totaling approximately $1,500,000 for such purported services. See United States v. Matthew Kolodesh, No. 11-cr-464 (E.D. Pa.), Dkt. Entry No. 1.

19. The federal grand jury further charged that approximately $9.36 million in fraudulently obtained Medicare payments was deposited into an HCH operating account and was then withdrawn and used to pay substantial sums to the alleged benefit and unjust enrichment of

defendant Kolodesh and his family.[3] See United States v. Matthew Kolodesh, No. 11-cr-464 (E.D. Pa.), Dkt. Entry No. 1.

20. Sentencing of defendant Kolodesh is currently scheduled for May 23, 2014.

21. Following the October 2013 conviction of Mr. Kolodesh, and retroactively effective to May 7, 2012, the Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services revoked the Provider Identification Number for defendant HCH that allowed HCH to bill Medicare for HCH services. As a consequence of that revocation, HCH ceased operations on December 31, 2013.

Guilty Plea of Defendant Pugman

22. On May 7, 2012, defendant Pugman pleaded guilty to a charge by Information of conspiracy on behalf of HCH to commit felony health care fraud on the Medicare Program, in violation of 18 U.S.C. § 1349. The Information charged, in part, that defendant Pugman and

[3] In September 2008, the United States filed a civil action in the Eastern District of Pennsylvania under the Anti-Fraud Injunction Statute, 18 U.S.C. § 1345, to enjoin defendants HCH, Pugman, Ganetsky, Kolodesh, and Yakobashvili from continuing what the United States alleged to be their ongoing fraud against the Medicare Program and to prevent them from dissipating assets that they accumulated as a result of the alleged fraud. See United States v. Home Care Hospice, Inc., et al., No. 08-cv-4711 (Davis, J.) ("the Section 1345 action"). On October 1, 2008, and as modified on November 12, 2008, Judge Davis granted the United States' motion for a temporary restraining order and preliminary injunction and, among other things, enjoined these defendants -- and financial institutions that were identified as holding the defendants' accounts -- from dissipating at-issue deposited monies. Following the October 2008 injunction, and until December 31, 2013, HCH continued business operations in compliance with the Court's orders. But whereas HCH previously had as many as 300 patients and 145 employees, after the injunction it averaged 10 to 15 patients and fewer than 10 employees. On October 27, 2008, Judge Davis ordered that the defendants could request limited disbursements from frozen accounts to pay for reasonable, necessary, and substantiated HCH medical obligations, such as purchases of medical supplies and payments of payroll. Limited such disbursements, as well as disbursements for defendants' attorneys' fees and for payment of taxes owed on the frozen accounts, were thereafter made from an HCH operating account. On January 6, 2014, in light of the December 31, 2013 closing of HCH, Judge Davis ordered the HCH operating account to be re-frozen.

others conspired to defraud Medicare by submitting fraudulent claims in the approximate amount of $14.3 million. Defendant Pugman pleaded guilty based upon his knowing and willful defrauding of Medicare between January 2003 and October 2008, by: (a) causing HCH to bill Medicare for ineligible routine care; (b) causing fraudulent upcoding of HCH's crisis care billings; and (c) fraudulently backdating hospice revocation forms. Defendant Pugman is scheduled to be sentenced on June 20, 2014. See United States v. Alex Pugman, No. 09-cr-651, Dkt. Entry Nos. 1, 7, 10, 35 (Robreno, J.).

Guilty Plea of Defendant Ganetsky

23. On June 1, 2012, defendant Ganetsky pleaded guilty to a charge by Information of obstruction (on behalf of HCH) -- in violation of 18 U.S.C. § 1516 -- of a February 2007 federal Medicare audit into HCH patients' eligibility for routine home care. Her plea agreement states that she "directed [HCH] employees and staff to alter records, backdate forms and discharge patients to conceal from the reviewers that [HCH] fraudulently billed Medicare for hospice services for ineligible patients." Defendant Ganetsky is scheduled to be sentenced on June 19, 2014. See United States v. Svetlana Ganetsky, No. 09-cr-652, Dkt. Entry Nos. 1, 11, 15, 38 (Robreno, J.).

Conviction of Former HCH Medical Director

24. On June 3, 2013, a federal jury in the Eastern District of Pennsylvania returned a guilty verdict against Eugene Goldman, M.D., who was HCH's Medical Director from 2000 until July 2011, on one count of conspiring to violate the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), and four counts of violating the Anti-Kickback Statute. Specifically, Dr.

Goldman was convicted based on charges that, as HCH medical director, he: (a) conspired with defendants Pugman and Ganetsky and others to solicit and receive "remuneration, including kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind in return for referring individual patients to [HCH]" for hospice services that were billed to Medicare and Medicaid; (b) entered into a written contract with defendant Pugman "to create the false appearance that all payments to [Dr.] Goldman from HCH [at the rate of $100/hour] were for services rendered in [his] capacity as Medical Director . . . when in reality this provided flexibility to . . . Pugman and . . . Goldman to mask payments for patient referrals"; and (c) between January 2004 and October 2008, received payments from HCH "totaling approximately $228,773 for Medicare and Medicaid patient referrals." On October 24, 2013, Dr. Goldman was sentenced to 51 months imprisonment, 3 years of supervised release, and payment of a $300,000 fine. See U.S. v. Eugene Goldman, M.D., No. 12-cr-305 (Robreno, J.).

Guilty Plea of Community Home Health Patient Care Coordinator

25. During the relevant period, Yanina Zlatkovskiy was a patient care coordinator for Community Home Health, a Bucks County, Pennsylvania home health agency that defendant Kolodesh owned and controlled until he sold it in November 2013. In that position, Ms. Zlatkovskiy was responsible for: (a) coordinating home health care for Community Home Health patients; (b) coordinating clinical staff assignments for patients on service with Community Home Health; and (c) between approximately April 2004 and November 2008, referring and arranging referrals of Medicare patient beneficiaries to HCH. On January 28, 2014, Ms. Zlatkovskiy entered a guilty plea to: (a) Count One of a May 1, 2013 federal grand jury Indictment charging her with conspiring with defendant Pugman, defendant Ganetsky, and others

to violate the Anti-Kickback statute, 42 U.S.C. § 1320a-7b(b), by soliciting and receiving, from approximately April 2004 to May 2009, remuneration including kickbacks and bribes, from Alex Pugman and Svetlana Ganetsky, in return for arranging for and recommending Medicare beneficiary patients to HCH for Medicare-reimbursable hospice service; and (b) Count Two of the Indictment charging her with violating the Anti-Kickback statute through that scheme. On April 29, 2014, the Court sentenced Ms. Zlatkovskiy to three years of probation, a criminal fine of $5,000, and a special assessment of $200. See United States v. Zlatkovskiy, No. 13-cr-213 (Robreno, J.).

Guilty Pleas and Convictions of HCH Staff

26. Among former HCH employees who, in connection with their HCH employment, have pleaded guilty to charges of health care (Medicare) fraud and aiding and abetting health care fraud in violation of 18 U.S.C. §1347 and 18 U.S.C. § 2 -- by falsifying nursing notes and home health aide documentation of patient care by HCH staff, in order to reflect "on paper" that a higher, more costly level of crisis care hospice service was furnished to patients than was actually provided -- are: (a) former HCH Office Manager Cecelia Wiley, who pleaded guilty to engaging in such conduct while under defendant Pugman's supervision from approximately September 2005 to March 2008 (United States v. Cecelia Wiley, No. 11-cr-322) (guilty plea entered June 28, 2012; sentencing scheduled for May 29, 2014); and (b) Edward Hearn, R.N. (United States v. Edward Hearn, No. 11-cr-297) (guilty plea entered May 9, 2013; sentencing scheduled for May 21, 2014).

27. Among former HCH employees who, in connection with their HCH employment, have pleaded guilty to conspiracy to commit health care fraud in violation of 18 U.S.C. § 1349 --

through falsification of nursing notes and home health aide documentation of patient care, in order to reflect "on paper" that a higher, more costly level of crisis care hospice service was furnished to patients than was actually provided, all while under the supervision of defendant Pugman -- are: (1) Yevgeniya Goltman, L.P.N. (February 2012 guilty plea; August 6, 2014 sentencing); (2) Giorgi Oqroshidze, R.N. (March 2014 guilty plea; June 12, 2014 sentencing); and (3) Alexsandr Koptyakov, L.P.N., for the period August 2005 to mid-2008 (March 2014 guilty plea; June 6, 2014 sentencing). All of these actions are pending at Criminal Action No. 12-cr-112 (Robreno, J.).

28. On March 25, 2014, a federal jury in the Eastern District of Pennsylvania convicted former HCH nurse Natalya Shvets, R.N., in connection with her HCH employment, of violations of 18 U.S.C. § 1349 (one count of conspiracy to commit health care fraud, from in or about January 2005 through in or about December 2008), 18 U.S.C. § 1347 (seven counts of health care fraud),[4] and 18 U.S.C. § 2 (aiding and abetting such health care fraud). Ms. Shvets' sentencing is scheduled for June 25, 2014. The action is pending at Criminal Action No. 12-cr-112 (Robreno, J.)

29. Among former HCH employees who, in connection with their HCH employment, have pleaded guilty to charges of fabricating documents and discharging patients to obstruct a February 2007 Medicare audit – and aiding and abetting such conduct -- in violation of 18 U.S.C. §§ 2 and 1516, are: (a) Diana A. Koltman, R.N. (United States v. Diana Koltman, No. 11-

[4] This included for submission of fraudulent Medicare continuous/crisis care claims for: (1) Patient R.F., from June 9 to 11, 2008; (2) Patient F.P., from March 24 to 28, 2007; (3) Patient T.P., from July 18 to 19, 2008; (4) Patient E.F., from May 11 to 15, 2007; (5) Patient W.W., from June 17 to 21, 2007; (6) Patient E.L., from March 31, 2007 to April 4, 2007; and (7) Patient R.Z., from June 9 to 11, 2007.

cr-182) (guilty plea entered June 6, 2012; sentenced on April 30, 2014 to five years' probation, criminal restitution of $405,184, and a $100 special assessment); (b) Lioudmila Novikov, R.N., whom HCH employed as both a nurse and Quality Assurance Supervisor (United States v. Lioudmila Novikov, No. 11-cr-189) (guilty plea entered August 17, 2012; sentencing scheduled for May 28, 2014); and (c) Eugenia Roytenberg, R.N. (United States v. Eugenia Roytenberg, No. 11-cr-84) (guilty plea entered June 21, 2012; sentenced on April 25, 2014 to five years' probation, criminal restitution of $405,184, and a $100 special assessment).

Estoppel Effect of Pleas and Convictions

30. Under the False Claims Act and common law, final judgments in the above-described criminal actions estop the defendants in this action – including HCH, which was a principal in privity with defendants Pugman, Ganetsky, Kolodesh, Yakobashvili, and other HCH employees described above, and is bound by their final judgments – from denying in this action the essential elements of the pleaded-to or convicted-on offenses involving the same transactions as are the subject of this Complaint. See False Claims Act, 31 U.S.C. § 3731(e) ("a final judgment rendered in favor of the United States in any criminal proceeding charging fraud or false statements, whether upon a verdict after trial or upon a plea of guilty[,] . . . shall estop the defendants from denying the essential elements of the offense in any action which involves the same transaction as in the criminal proceeding and which is brought under subsection (a) or (b) of [the False Claims Act, 31 U.S.C. § 3730]"); see also, e.g., Allen v. McCurry, 449 U.S. 90, 104 n. 22 (1980).

31. HCH and its officers are, moreover, vicariously liable under the False Claims Act for the fraud of their agents, who acted with actual and/or apparent authority from HCH.

II. JURISDICTION AND VENUE

32. This Court has subject-matter jurisdiction over this action pursuant to 28 U.S.C. §§ 1331 and 1345, and supplemental jurisdiction to entertain common law or equitable claims for unjust enrichment pursuant to 28 U.S.C. § 1367(a).

33. This Court has personal jurisdiction over the defendants pursuant to 31 U.S.C. § 3732(a), because defendants have transacted business in the Eastern District of Pennsylvania, caused the submission of false or fraudulent claims in this District, and reside in this District.

34. Venue is proper in the Eastern District of Pennsylvania under 31 U.S.C. § 3732(a), and 28 U.S.C. § 1391(b) and (c), because the defendants have transacted business in this District and reside in this District.

III. PARTIES

35. Plaintiff United States brings this action on behalf of the United States Department of Health and Human Services ("HHS") and its operating division, the Centers for Medicare & Medicaid Services ("CMS"). At all times relevant to this Complaint, CMS was an operating division of HHS that administered and supervised the Medicare Program.

36. Relator Robert Fox is the Administrator of the Estate of Maureen Fox, deceased. Relator Fox resides in the Eastern District of Pennsylvania.

37. Relator Cathy Gonzales resides in the Middle District of Pennsylvania.

38. At all relevant times, HCH was a Pennsylvania corporation. During the relevant period, until approximately February 2006, HCH's office was located at 1810 Grant Avenue, Philadelphia, Pennsylvania. In February 2006, HCH relocated to 2801 Grant Avenue in Philadelphia. At these Grant Avenue offices, which served as its business hub, HCH:

(a) scheduled and assigned nurses and aides to provide purported care for hospice patients in various field (that is, non-HCH) locations; (b) conducted patient care coordination (interdisciplinary team) meetings; (c) reviewed patient charts; (d) stored and retained patient files and records; and (e) billed Medicare and other insurance plans for reimbursement for purported hospice services.

39. At all relevant times, defendant Alex Pugman, a registered nurse, was a 50 percent owner of HCH as well as its Executive Director and Secretary. Since 2004, he has resided at 197 Edwards Drive, Churchville, Pennsylvania 18966. As HCH Director, he oversaw and controlled HCH's daily operations. Those duties primarily involved supervision of: (a) clinical care; (b) professional services; (c) development and marketing activities; (d) payroll; (e) claims submissions and quality assurance; and (f) billing procedures. Additionally, defendant Pugman supervised at least 60 HCH field personnel who were essential to HCH's operation, including: nurses and home health aides; an officer manager; a director of professional services with oversight over the nursing and clinical staff; patient care managers for the nursing teams; a quality assurance supervisor; marketing representatives; billing clerks; and a bookkeeper, among others. From time to time, defendant Pugman also treated HCH hospice patients in the field. As averred further below, at all relevant times defendants Pugman and Kolodesh controlled HCH's financial operations.

40. At all relevant times, defendant Svetlana Ganetsky, who is defendant Pugman's wife, was a licensed physical therapist and HCH's Development Executive, who since 2004 has resided with her husband at 197 Edwards Drive, Churchville, Pennsylvania 18966. Under defendant Pugman's supervision, defendant Ganetsky's primary duties included marketing HCH

to health care professionals. She also directed the admission and discharge of hospice patients to and from HCH.

41. Defendant Matthew Kolodesh: (a) incorporated and organized HCH in 1999; (b) recruited defendant Pugman as a business partner to run HCH; and (c) instructed defendant Pugman on the various aspects of operating a health care business, including on billing and claims submissions, marketing, obtaining and increasing patient referrals, and financial matters. Since 2004, defendant Kolodesh has resided next door to defendants Pugman and Ganetsky, at 193 Edwards Drive, Churchville, Pennsylvania 18966. At all relevant times, he: (a) was familiar with the health care industry; (b) with defendant Pugman, controlled the financial operations of HCH, including the disbursement of funds from the HCH operating account, which received funds from Medicare for claims submitted by HCH for hospice services purportedly provided to patients; and (c) routinely consulted with defendant Pugman on all major matters regarding HCH operations.

42. Since 2004, defendant Malvina Yakobashvili, who is defendant Kolodesh's wife, has resided with him at 193 Edwards Drive, Churchville, Pennsylvania 18966. At all relevant times, defendant Yakobashvili: (a) held a 50 percent ownership in HCH; and (b) was HCH's Chief Executive Officer and Treasurer. Defendant Yakobashvili in fact merely functioned as the nominee owner for defendant Kolodesh, exercised no real control over HCH, and had no real role in the operation of its business. Defendant Yakobashvili did, however, profit from the fraudulent claims that HCH submitted to Medicare.

43. Apart from his *de facto* ownership and control of HCH, defendant Kolodesh, at all relevant times, also owned and controlled Community Home Health, a home health agency

located in Bucks County, Pennsylvania, which he sold in November 2013. Community Home Health routinely referred patients to HCH and also admitted patients discharged from hospice services by HCH.

44. During the relevant period, funds deposited into the HCH operating accounts from fraudulently obtained Medicare payments were disbursed to pay HCH operating expenses, salaries of HCH staff, and salaries and bonuses of HCH officers (including of defendants Pugman, Ganetsky, and Yakobashvili), among other things. Substantial funds from the HCH operating accounts were also disbursed to personal accounts of defendants Pugman, Ganetsky, Kolodesh, and Yakobashvili, and to various business entities controlled by them.

45. During the relevant period, funds deposited into the HCH operating accounts from fraudulently obtained Medicare payments -- funds that were withdrawn and used by defendants Kolodesh and Yakobashvili, to their unjust enrichment -- were specifically withdrawn to pay for:
(a) approximately $5.35 million in salary and bonuses to defendant Yakobashvili;
(b) approximately $98,000 for extensive home renovations to these defendants' home, as well as for their travel expenses, their luxury automobile, over $62,000 in college tuition for their son, and $5,700 in bogus salary for their son; (c) approximately $3.56 million in disbursements to various business partnerships owned and controlled by defendant Kolodesh individually or with defendant Yakobashvili and/or defendant Pugman; (d) approximately $529,438 in cash disbursements, based upon the systematic use of phony invoicing to create the appearance that HCH was paying for bona fide goods and services when, in reality, invoices were routinely inflated or falsified to enable defendants Kolodesh and Pugman to issue checks from the HCH operating account to vendors who would kick back a percentage of the invoices, resulting in

approximately $216,500 in cash payments to defendant Kolodesh; and (e) approximately $148,100 in checks issued to a synagogue -- creating the appearance of a charitable donation, when, in reality, a percentage of the "donation" was returned in cash payment to defendant Kolodesh, totaling approximately $55,700.

IV. THE FALSE CLAIMS ACT

46. The False Claims Act, 31 U.S.C. §§ 3729-33, provides for the award of treble damages and civil penalties for a variety of false and fraudulent practices.

47. Specifically, during the relevant period, 31 U.S.C. § 3729(a)(1) (2006) imposed liability on 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[.]

48. Additionally, 31 U.S.C. § 3729(a)(1)(B) retroactively imposed liability on any person who:

> knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim.[5]

49. "Material," as used in Section 3729(a)(1)(B), is defined as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property."

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[5] In May 2009, the False Claims Act was amended under the Fraud Enforcement and Recovery Act of 2009 ("FERA"). Although subsection 3729(a) was amended in various respects, the only FERA-amended, non-definitional provision of the False Claims Act that applies to the January 2003 to October 2008 conduct in this case is subsection 3729(a)(1)(B), which applies retroactively based upon FERA, subsection 4(f) *("The amendments made by this section shall take effect on the date of enactment of the Act and shall apply to conduct on or after the date of enactment, except that (1) subparagraph (B) of section 3729(a)(1), as added by subsection (a)(1), shall take effect as if enacted on June 7, 2008, and apply to all claims under the False Claims Act . . . that are pending on or after that date[.]"*). Otherwise, pre-FERA provisions of the False Claims Act, including subsections 3729(a)(1) and (a)(3), apply in this action.

50. Additionally, during the relevant period, 31 U.S.C. § 3729(a)(3)(2006), imposed liability on any person who:

> conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

51. Further, the FCA, 31 U.S.C. § 3729, provides that:

> (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.

52. The standard of proof under the FCA is preponderance of the evidence. 31 U.S.C. § 3731(d).

V. THE MEDICARE HOSPICE PROGRAM

Hospice Services Covered

53. Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, et seq., establishes the Health Insurance for the Aged and Disabled Program, commonly referred to as the Medicare Program (or "Medicare").

54. The Medicare Program consists of four parts. Medicare Parts B, C, and D are not directly at issue in this case.

55. Part A of the Medicare Program is a 100-percent federally funded health insurance program for: (a) qualified residents of the United States who are aged 65 and older; and (b) persons with qualifying disabilities. The majority of Medicare Part A's costs are paid by United States citizens through their payroll taxes. The benefits that are covered by Part A of the Medicare Program include hospice care under 42 U.S.C. §§ 1395x(dd).

56. In order to be eligible to elect hospice care under Medicare, an individual must be: (a) entitled to Part A of Medicare; and (b) certified as terminally ill in accordance with 42 C.F.R. § 418.22. See 42 U.S.C. § 1395f(a)(7)(A); 42 C.F.R. § 418.20. As defined at 42 C.F.R. § 418.3, "terminally ill" means that a person "has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course."

57. Hospice is available to such terminally ill individuals for two initial 90-day periods, and then for an unlimited number of further 60-day periods, as long as certain conditions are met and medical certifications are provided, as described below. See Medicare Benefit Policy Manual, Chapter 9, §§ 10, 20.1.

58. Hospice is a program designed to provide patients with palliative care (i.e., care designed to relieve pain, symptoms, or stress of terminal illness) instead of curative care (i.e., care designed to cure an illness or condition). Hospice palliative care includes a comprehensive set of medical, social, psychological, emotional, and spiritual services for terminally ill individuals.

59. To be covered for Medicare Part A reimbursement, hospice services must be reasonable and necessary for the palliation and management of a patient's terminal illness as well as related conditions. Medicare outlines the admission criteria for various illnesses.

60. Medicare recipients must elect hospice care (i.e., it is voluntary) and, in doing so, agree to forgo curative care for their terminal illnesses. Electing hospice care is thus a critical medical decision for a patient who has been informed that his or her death is imminent. That election also affects Medicare payment for further care. Following election of the hospice benefit, for example, if a hospice patient entered a hospital and received curative treatment

related to a diagnosis that had made the patient eligible for hospice, the hospice agency itself would be required to pay the patient's hospital expenses. But if the patient had revoked his or her election of hospice, then at the time of revocation the patient would be deemed discharged from the hospice agency, the hospice agency would thereafter no longer be responsible for hospitalization costs, and those costs would then become covered by Medicare benefits different from the hospice benefit.

61. Crisis care (continuous care) is: (a) for a patient who elects to receive hospice care at home, or in a long-term facility such as a nursing home; and (b) provided when the hospice patient is experiencing a "brief period[] of crisis," and only as necessary to allow the patient to remain at his or her residence. 42 C.F.R. § 418.302(b)(2). Medicare defines a brief "period of crisis" as "a period in which the individual requires continuous care to achieve palliation and management of acute medical symptoms." Id. at § 418.204(a).

62. To bill Medicare for crisis care, a hospice must provide care that is: (a) designed to palliate the patient's acute medical symptoms; (b) provided to the patient for at least eight hours in a 24-hour period, counted from midnight to midnight; and (c) predominantly nursing care, meaning care provided by a registered nurse (RN), licensed practical nurse (LPN), or nurse practitioner (NP). See 42 C.F.R. § 418.302, 418.204. If the care lasts fewer than eight hours in a 24-hour period, the hospice may bill Medicare only for routine home care for that day of hospice services. Similarly, if the care provided does not consist predominantly of nursing care, then the hospice may not bill Medicare for crisis care and must instead bill for routine home care. See id.

Obligations Of The Hospice Provider

63. All Medicare providers are expected to deal honestly with the United States Government and with patients.

64. In addition, all health care providers must comply with applicable statutes, regulations, and guidelines in order to be reimbursed by Medicare Part A. When participating in Medicare, a provider has a duty to be knowledgeable of the statutes, regulations, and guidelines for coverage of Medicare services, and, in the case of hospice care, to know that Medicare reimburses only for services that are reasonable and necessary for the palliation or management of terminal illness. See 42 U.S.C. § 1395y(a)(1)(C).

65. HCH -- which during the relevant period was a Medicare provider that received millions of dollars in hospice revenue, the overwhelming preponderance of which was paid by Medicare -- as well as its officers, directors, and owners, had a duty: (a) to have thorough knowledge of the Medicare hospice program; and (b) properly to train and inform HCH's employees regarding the requirements for Medicare coverage of hospice services.

66. One of the purposes of the Medicare hospice requirements is to ensure that limited Medicare funds are properly spent on patients who are dying and need end-of-life care.

67. It is a condition of provider participation in Medicare Part A that hospices must maintain, for each hospice patient, a clinical record that contains "correct clinical information." 42 C.F.R. § 418.104. All entries in the clinical record must be "legible, clear, complete, and appropriately authenticated and dated[.]" 42 C.F.R. § 418.104(b).[6]

[6] The regulation governing clinical records was revised in 2008. The regulation previously was located at 42 C.F.R. § 418.74 and required that hospices "maintain a clinical record for every individual receiving care and services. The record must be completed promptly and accurately documented[.]"

68. For a patient to be eligible for the Medicare hospice benefit for a particular election period, and for a hospice provider to be able to bill for hospice care, the patient's medical records that are created and maintained by the hospice must include "[c]linical information and other documentation that support the medical prognosis" of a life expectancy of six or fewer months if the illness runs its normal course. 42 C.F.R. § 418.22(b)(2). See also 170 Fed. Reg. 70532, 70534-35 (Nov. 22, 2005) (noting the same).

69. For the initial 90-day hospice period, the hospice provider must obtain a certification of a patient's terminal illness from (a) the medical director of the hospice or physician-member of the hospice's interdisciplinary group, and (b) the individual's attending physician, if the individual has an attending physician.[7] For subsequent periods, the hospice provider must obtain the certification of terminal illness from either the medical director of the hospice or a physician who is a member of the hospice's interdisciplinary group for the patient. 42 U.S.C. § 1395f(a)(7)(A); 42 C.F.R. § 418.22.

70. Such written certifications of terminal illness must include, among other things: (a) a statement that the patient's prognosis is of a life expectancy of six or fewer months if the terminal illness runs its normal course; (b) specific clinical findings and other documentation that support a determination that the patient has a life expectancy of six or fewer months; and (c) the signature(s) of the physician(s) attesting to these medical conclusions. "A signed certification, absent a medically sound basis that supports the clinical judgment, is not sufficient for

[7] As specified by 42 C.F.R. § 418.56, the interdisciplinary group should consist of, at a minimum, a physician, a registered nurse, a social worker, and a pastor or other counselor. The interdisciplinary group is responsible for coordinating each patient's care, ensuring continuous assessment of each patient's and family's needs, and implementing an interdisciplinary plan of care.

application of the hospice benefit under Medicare." 170 Fed. Reg. 70534-35; 42 C.F.R. § 418.22.

71. Medicare requires that at least eight hours of primarily nursing care are needed to manage an acute medical crisis. Furthermore, "[w]hen a hospice determines that a beneficiary meets the requirements for [crisis care], appropriate documentation must be available to support the requirement that the services provided were reasonable and necessary and were in compliance with an established plan of care in order to meet a particular crisis situation. This would include the appropriate documentation of the situation and the need for continuous care services consistent with the plan of care." Medicare Benefit Policy Manual, Chapter 9, § 40.2.1.

The Medicare Hospice Payment Process

72. The United States reimburses Medicare providers with payments from the Medicare Trust Fund, through CMS, as supported by American taxpayers. CMS, in turn, contracts with Medicare Administrative Contractors -- which are Medicare claims processors, also known as "MACs," and were formerly known during the relevant period as "fiscal intermediaries" -- to review, approve, and pay Medicare bills, called "claims," received from health care providers like HCH.

73. During the relevant period, Cahaba Government Benefit Administrators ("Cahaba") was the CMS federal contractor responsible for claims oversight for hospice providers in Pennsylvania and elsewhere and acted on behalf of CMS as the fiscal intermediary responsible for processing the payment of Part A claims from HCH.

74. Payments are typically made by Medicare directly to health care providers like HCH, rather than to the patient. The Medicare beneficiary usually assigns his or her right to Medicare payment to the provider.

75. The Medicare provider either submits its bill directly to Medicare for payment, or it contracts with an independent billing company to submit a bill to the MAC or fiscal intermediary, on the provider's behalf.

76. Because it is not feasible for the Medicare Program, or its contractors, to review the patient files for the hundreds of millions of claims for payments that Medicare receives from hospice providers, the Medicare Program relies upon the hospice providers to comply with the Medicare requirements, and trusts the providers to submit truthful and accurate claims.

77. Hospice providers are reimbursed based upon their submission(s) of an electronic or hard-copy form that is currently called a "CMS-1450 form." This form contains information related to the identity of the patient, the hospice's provider number, the patient's principal diagnosis, the medical necessity of the services rendered, the date of the patient's certification or re-certification as being terminally ill, the location(s) where hospice services were provided, and the level of hospice care provided (i.e., routine home care, crisis (continuous) care, respite care, or general inpatient care).

78. On the claim form, the provider certifies that the claim "is correct and complete," that "[p]hysician's certifications and re-certifications, if required by contract or Federal regulations, are on file," and that "[r]ecords adequately disclosing services will be maintained and necessary information will be furnished to government agencies as required by applicable law."

79. All Medicare providers must have, in all of their patients' files, the medical documentation to establish that the Medicare items or services for which they have sought Medicare reimbursement are reasonable and medically necessary.

80. The physician certifications and other documents that support a claim that a hospice provider makes to Medicare are submitted to Medicare only if the claim for hospice services is selected for medical review, which does not happen routinely. See Medicare Claims Processing Manual, Chapter 11, *Processing Hospice Claims*; Medicare Program Integrity Manual, Chapter 3, *Verifying Potential Errors and Taking Corrective Actions*. Additionally, in such medical review circumstances, it is the hospice provider -- and not the patient's primary care or treating physician -- who is required to submit to Medicare the underlying documentation that supports the eligibility determination and the claim.

81. Once a provider submits the CMS-1450 form or its equivalent to the MAC or fiscal intermediary, the claims are paid directly to the provider.

82. Federal law requires providers like HCH that receive funds under the Medicare Program to report and return any overpayments within specified time periods. 42 U.S.C. § 1320a-7k(d).

83. Fiscal intermediaries such as Cahaba issued, and MACs issue, Local Coverage Decisions ("LCD") to provide guidance to the public and medical community within their jurisdictions on the clinical circumstances under which a service is considered to be reasonable and necessary and thus covered by Medicare. Fiscal intermediaries and MACs develop LCDs by "considering medical literature, the advice of local medical societies and medical consultants,

public comments, and comments from the provider community." Medicare Program Integrity Manual, Chapter 13, § 13.1.3.

84. LCDs also advise that: "If a patient improves or stabilizes sufficiently over time while in a hospice such that he/she no longer has a prognosis of six months or less from the most recent recertification evaluation or definitive interim evaluation, that patient should be considered for discharge from the Medicare hospice benefit."

85. On November 22, 2005, CMS released a Final Rule, effective January 23, 2006, revising 42 C.F.R. § 418 to require hospices to put in place a "discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill." 42 C.F.R. § 418.26(d).

86. During the relevant period, HCH, as a hospice provider, submitted claims for Medicare reimbursement to Cahaba, as fiscal intermediary, for each day that a patient was enrolled in HCH hospice care. Medicare paid those claims based upon the level of hospice care that HCH claimed to have provided.

VI. THE IMPROPER CONDUCT OF DEFENDANTS

A. Defendants HCH, Pugman, Ganetsky, and Kolodesh Submitted Or Caused To Be Submitted False and Fraudulent Claims And False Records and Reimbursement Statements -- And Conspired To Get Such Claims Allowed Or Paid -- For Patients Not Meeting The Medical Criteria For End-Of-Life Care

87. For a substantial number of patients who were not "terminally ill" with a prognosis of six or fewer months to live if their illnesses ran a normal course, and who were therefore not eligible to receive end-of-life care, defendants HCH, Pugman, Ganetsky, and Kolodesh, from at least January 2003 to October 2008: (a) knowingly submitted or caused to be

submitted false or fraudulent claims to Medicare for HCH hospice care; (b) created, submitted, or caused to be submitted documentation that falsely represented eligibility for, and receipt of, hospice care; and (c) conspired among themselves with the common purpose of defrauding the government by getting -- and acting to get -- Medicare to pay for such false or fraudulent claims.

88. The Information to which defendant Pugman pleaded guilty, and the Indictments on which defendant Kolodesh and Eugene Goldman, M.D. were found guilty, charged that, during the relevant period (a) defendants Kolodesh and Pugman, (b) in order to bolster HCH's patient census, (c) authorized payments, in cash or by check, to certain physicians and other health care professionals, (d) as an incentive to refer patients to HCH and to certify that patients were appropriate for hospice services, (e) when, in reality, many of the patients were not eligible or appropriate for hospice care. It was further charged that, in other instances, physicians and other health care professionals were paid by defendant Pugman to serve as HCH medical directors, hospice physicians, and advisors when, in reality the contracts for those positions masked payments for patient referrals.

89. Defendant Pugman pleaded guilty to an Information charging him, in part, with conspiring with other persons, between January 2003 and October 2008, to defraud Medicare by engaging in the following conduct:

> Defendant . . . Pugman, in order to increase HCH revenues, authorized the submission of claims to Medicare which defendant Pugman knew were false and fraudulent in that defendant Pugman represented: (a) HCH patients were eligible for routine hospice care at the approximate rate of $140 per day when, in reality, approximately 30% of the patients admitted to HCH were ineligible for hospice care, in that the patients did not have a terminal illness with a life expectancy of six months or less, for which HCH fraudulently obtained payments from Medicare totaling approximately $12,500,000[.] . . .

> Defendant . . . Pugman directed and authorized certain individuals with HCH management, nursing staff and nursing supervisors to place and maintain ineligible patients, who were not terminally ill, on hospice care. In fact, a substantial portion of HCH patients were on hospice service for periods in excess of six months, and in some instances for more than one year.

90. Defendant Ganetsky pleaded guilty to an Information charging that:

> From in or around January 2003 to in or about October 2008, Alex Pugman, as the Director of HCH, authorized the submission of claims to Medicare which were false and fraudulent, in that: (a) approximately 30% of HCH patients were ineligible for hospice care in that the patients did not have a terminal illness with a life expectancy of 6 months or less, for which HCH fraudulently received payment from Medicare totaling approximately $12,500,000[.]

91. The Indictment on which defendant Kolodesh was found guilty charged that, during the relevant period: (a) defendant Kolodesh directed and authorized defendant Pugman to instruct HCH management, nursing staff, and nursing supervisors to place and maintain ineligible patients who were not terminally ill on hospice care; and (b) in fact, a substantial portion of HCH patients were on hospice services for periods in excess of six months, and in some instances for more than one year.

92. As charged in the Information to which defendant Pugman pleaded guilty, and in the Indictment on which defendant Kolodesh was found guilty, during the relevant period defendant Kolodesh authorized defendant Pugman to direct -- and defendant Pugman directed and authorized -- HCH management, nursing staff, and nursing supervisors to fabricate supporting documentation for patient files to substantiate approximately $12.8 million in fraudulent claims that HCH submitted to Medicare for ineligible patients. This fabrication of documents routinely involved the alteration of patient charts and the falsification of nursing

notes, in order to create the appearance "on paper" that patients' medical conditions were worse than they actually were. This fabrication of documents was often accomplished by changing diagnoses and showing patients' decline, through, for example, falsified statements of weight loss, fevers, medications taken, or infections, among other things.

93. In late June 2006, an inspector from the Pennsylvania Department of Health, in an unannounced complaint investigation, reviewed the charts of 20 patients whom HCH had certified as being eligible for hospice care. A few days later, the inspector issued a report: (a) finding HCH out of compliance with 42 C.F.R. Part 418 conditions of participation; and (b) stating that HCH had inappropriately placed in hospice care 11 of the 20 patients, and that for those 11 patients there was a lack of documentation of continuing decline. One such patient, for example, had been initially certified for hospice care in 2004.

94. As charged in part in an Information to which defendant Pugman pleaded guilty and in an Information to which defendant Ganetsky pleaded guilty, fiscal intermediary Cahaba, as a Medicare contractor, on February 23, 2007 notified defendants Pugman and HCH that HCH was subject to a mandatory review audit of randomly selected claims involving the eligibility of 20 HCH patients for routine home care. (Although an audit, this review was referred to as the "Probe Edit"). As part of the Probe Edit, Cahaba required HCH to produce patient records and supporting documents.

95. As further charged in part in an Information to which defendant Pugman pleaded guilty and in an Information to which defendant Ganetsky pleaded guilty, as well as in the Indictment on which defendant Kolodesh was convicted, from March 2007 through April 2007, to conceal from Medicare contractor Cahaba during the Probe Edit that HCH submitted false

claims for patients who were ineligible for hospice services, defendants Pugman and Ganetsky, as authorized by defendant Kolodesh, directed members of HCH's management and nursing staff and HCH's nursing supervisors to: (a) alter patient charts to change diagnoses (and show patients' declines through, for example, falsified statements of weight loss, fevers, medications taken, and the onset of infection); and (b) falsify nursing notes and forms, and fabricate supporting documentation, to submit to Cahaba in order to reflect falsely that patients' medical conditions were worse than they actually were.

96. Based upon these falsified records, Medicare, through its contractor Cahaba, approved payment for all of the reviewed billings.

97. To manage Medicare claims payments, the Medicare regulations provide for an annual "Cap" on the amount of reimbursement that each facility operated by a hospice provider is eligible to receive during each Medicare fiscal year (the "Cap Period"). 42 C.F.R. §§ 418.301, 418.309. A facility's Medicare Cap number depends on the number of Medicare beneficiaries the provider enrolls during the applicable Cap Period and is calculated at the end of the Cap Period. If a provider exceeds the Cap during the Cap Period, the provider must refund the overage/overpayment to Medicare.

98. On September 19, 2007, Cahaba notified HCH that it was required to reimburse Medicare in the sum of $2,625,047 for the overpayment of claims -- based on exceeding the Cap -- that HCH submitted to Medicare for the fiscal year ending in 2005. Although Cahaba later agreed with HCH that there was, in fact, no Cap overpayment for fiscal year 2005, defendant Kolodesh, in October 2007, in order to avoid further Medicare Cap scrutiny for fiscal years 2006 and 2007, directed defendant Pugman to review HCH patient files and discharge HCH hospice

patients en masse, which resulted in the immediate discharge of approximately 79 patients in October 2007. By January 2008, HCH had discharged a further 49 patients. These were patients whom defendants Kolodesh and Pugman knew to be ineligible for hospice care and who had been inappropriately maintained on hospice services in excess of six months. Approximately 16 patients who were thus discharged were admitted to Community Home Health, which defendant Kolodesh owned and controlled.

99. Defendant Kolodesh advised defendant Pugman that, after Medicare Cap concerns were resolved, patients who had been discharged from HCH could be returned to the HCH patient census. Approximately 11 patients who had been discharged from HCH and then admitted to Community Home Health were later discharged from Community Home Health and returned to HCH.

100. During the relevant period, HCH falsely certified on electronic claim forms that it submitted or caused to be submitted to Medicare, through its responsible contractor, Cahaba, that its claims were "correct and complete," that the provided care was "medically indicated and necessary for the health of the patient," and that it maintained documentation on file in compliance with the certification requirements of 42 C.F.R. § 41.22.

101. These claim submissions were false because HCH created, submitted, and/or caused to be submitted documentation that falsely represented that certain Medicare recipients were "terminally ill." Many of the Medicare recipients were not eligible for hospice care paid for by the Medicare Program because they did not have prognoses of six or fewer months to live if their illnesses ran a normal course.

102. A hospice provider such as HCH is expected to know and understand the Medicare statute, the definition of "terminally ill," and the local coverage determinations that provide guidance on the medical criteria for determining whether individuals with certain diagnoses have a prognosis of six or fewer months to live. One of the purposes of the Medicare requirements is to ensure that limited Medicare funds are properly spent on patients who are dying and need end-of-life care.

103. Defendants HCH, Pugman, Ganetsky, and Kolodesh knew, deliberately ignored, or recklessly disregarded that the claims that HCH submitted or caused to be submitted to Medicare falsely represented the appropriateness of patients for end-of-life care and the patients' eligibility for the Medicare hospice benefit. In addition, defendants HCH, Pugman, Ganetsky, and Kolodesh knew, deliberately ignored, or recklessly disregarded that HCH's internal practices would lead to the submission of false claims to Medicare for hospice services provided to ineligible beneficiaries.

104. The false claims, records, and statements that defendants HCH, Pugman, Ganetsky, and Kolodesh created, submitted, or caused to be submitted and that falsely represented patients' eligibility for, and receipt of, hospice care -- including terminally ill certifications and re-certifications -- were material to the United States' payment decisions because they led the government to make Medicare payments that it otherwise would not have made.

105. As a result of defendants' submissions of claims that were knowingly false, or submitted with reckless disregard or in deliberate ignorance of their falsity, the United States was

damaged by reimbursing HCH, through Medicare, for providing hospice care to patients who were not eligible for the hospice benefit.

Examples of False Claims for Specific, Ineligible Patients[8]

Patient J.H.

106. HCH, Pugman, Ganetsky, and Kolodesh knowingly submitted or caused to be submitted false or fraudulent claims to Medicare -- and conspired to defraud the government by getting false or fraudulent claims to Medicare paid -- for HCH hospice care to Patient J.H. at an assisted living facility, from December 15, 2006 to October 10, 2007, in the amount of $44,456.23.[9] Medicare paid the claims in the amount of $44,454.24.

107. As testified to by former HCH Office Manager Cecelia Wiley, although HCH's records state that J.H. had end-stage coronary artery disease between December 2006 and October 2007, in fact he was caring for himself, was driving his own car, did not have a terminal illness with a prognosis of six or fewer months to live if his disease ran its normal course, and was not appropriate for hospice services.

108. To maintain J.H. on hospice care notwithstanding his ineligibility, defendant Pugman directed Ms. Wiley to alter J.H.'s records to state falsely that he was reliant on HCH

[8] To protect patient privacy, the United States identifies only by initials, not full names, individual patients who, by way of example, the False Claims Act defendants knew were not eligible for end-of-life care that was billed by HCH to Medicare. The United States will serve defendants with a list identifying each patient by name and patient identification number.

[9] These were claims numbered: (1) 20700400165404; (2) 20701700707304; (3) 20712101509204; (4) 20703700331404; (5) 20705100624904; (6) 20732301067904; (7)20706400813604; (8) 20707800410204; (9) 20732301069704; (10) 20709400398404; (11) 20710900398604; (12) 20712200701504; (13) 20732301071304; (14) 20714100400204; (15) 20732500451804; (16) 20715700124604; (17) 20717201095704; (18) 20732500454104; (19) 20718400429704; (20) 20720000408504; (21) 20734500134304; (22) 20721400767204; (23) 20722800550704; (24) 20734500211404; (25) 20724900325104; (26) 20726200493504; (27) 20727600685504; (28) 20814200175204; and (29) 20729000719104.

care rather than self-care. Then, at Ms. Wiley's direction, one of HCH's home health aides altered J.H.'s records in accordance with defendant Pugman's instructions.

Patient B.K.

109. HCH, Pugman, Ganetsky, and Kolodesh knowingly submitted or caused to be submitted false or fraudulent claims to Medicare -- and conspired to defraud the government by getting false or fraudulent claims to Medicare paid -- for HCH hospice care to Patient B.K. at her home from December 15, 2006 to March 23, 2007, in the amount of $14,348.18.[10] Medicare paid the claims in the amount of $14,348.12.

110. HCH's medical records for B.K. -- and testimony of former HCH nurse Eugenia Roytenberg, R.N. -- evidence that B.K. was not appropriate or eligible for hospice services. Although HCH's records state that B.K. had end-stage coronary artery disease between December 2006 and March 23, 2007 (the date on which she was discharged from HCH hospice service), in fact B.K. did not have a terminal illness with a prognosis of six or fewer months to live if her disease ran its normal course, required only general custodian medical care such as blood pressure monitoring, and was thus not appropriate for hospice services. As of May 9, 2014, B.K. is still alive.

111. B.K.'s medical chart was among the patient charts that Medicare contractor Cahaba reviewed for its 2007 Probe Edit. After Cahaba requested HCH to provide B.K.'s chart, and before providing the chart to Cahaba, defendant Pugman acted to conceal from Cahaba and Medicare that B.K. was not and had not been appropriate for hospice care, and that HCH had

[10] These were claims numbered: (1) 20700400977504; (2) 20701800670704; (3) 20703800824404; (4) 20705200647704; (5) 20706600468604; (6) 2070780068404; and (7) 20710900646804.

submitted false and fraudulent claims for HCH hospice care for B.K. when she was ineligible for hospice services.

112. Specifically, defendant Pugman: (a) during the relevant period in 2007, raised by five pounds a stated weight of B.K. in a June 2006 "worksheet for determining hospice eligibility" -- thus falsely reflecting that B.K. had a higher "pre-illness" weight than her actual pre-HCH weight -- in order to justify hospice services on grounds that B.K.'s condition (as evidenced by weight loss) was declining while at HCH; and (b) while standing next to HCH nurse Eugenia Roytenberg, R.N., who was assigned to care for B.K., instructed Roytenberg to enter into B.K.'s medical records (and Roytenberg then did enter into the records) a false March 8, 2007 narrative aimed at justifying hospice services for B.K. In testimony, Roytenberg translated her medical shorthand in the narrative as follows: "Spoke with MD about patient anxiety, chest pain, increased blood pressure. I wrote a report about nursing interventions and instructions given to family. Doctor instructed to monitor patient. I then spoke with patient's daughter about management of pain, respiratory distress and anxiety." In fact, no such conversations with B.K.'s doctor and with her daughter had occurred.

113. These falsified medical records for B.K. were provided to Cahaba for its Probe Edit. Medicare, through its contractor Cahaba, approved payment for all of the reviewed billings.

Patient M.M.

114. HCH, Pugman, Ganetsky, and Kolodesh knowingly submitted or caused to be submitted false or fraudulent claims to Medicare -- and conspired to defraud the government by getting false or fraudulent claims to Medicare paid -- for HCH hospice care to Patient M.M. at

his home from March 16, 2007 through April 25, 2007, in the amount of $6,002.81.[11] Medicare paid the claims in the amount of $6,002.79.

115. HCH's medical records for M.M. -- and testimony of former HCH nurse Eugenia Roytenberg, R.N. and former HCH nurse and Quality Assurance supervisor Lioudmila Novikov, R.N. -- evidence that, though HCH's records state that M.M. had end-stage dementia between March 16, 2007 and April 25, 2007, in fact M.M. did not have a terminal illness with a prognosis of six or fewer months to live if M.M.'s disease ran its normal course. M.M. thus was not appropriate for hospice services.

116. M.M.'s HCH chart was among the patient charts that Medicare contractor Cahaba reviewed for its early-2007 Probe Edit. After Cahaba requested HCH to provide M.M.'s chart, and before providing M.M.'s medical records to Cahaba for its review, defendant Pugman acted to conceal from Cahaba and Medicare that M.M. was not and had not been appropriate for hospice care, and that HCH had submitted false claims for HCH hospice care for M.M. when he was ineligible for hospice services.

117. Specifically, defendant Pugman directed that a "worksheet for determination of hospice eligibility" record for M.M. be both backdated to February 22, 2007 and otherwise falsified (and the worksheet was then falsified by HCH staff) to state a February 20, 2007 patient weight of 146.5 pounds. This contradicted an original February 22, 2007 worksheet that had recorded a February 14, 2007 patient weight of 180.5 pounds. Defendant Pugman so directed in response to the Cahaba audit (Probe Edit) and in order to justify hospice services on grounds that M.M.'s condition (as evidenced by weight loss) was declining.

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[11] These were claims numbered: (1) 20714200757704; and (2) 20714200765204.

118. Defendant Pugman further directed that March 1 to 7, 2007 HCH patient records for M.M. be altered and created to state (and such records were then altered and created by HCH staff to state), falsely, that M.M. was being treated with the antibiotic Levaquin for signs and symptoms of aspiration with infection. Defendant Pugman so directed in response to the Cahaba audit (Probe Edit) and in order to justify hospice services on grounds that M.M.'s condition (as evidenced by infection) was declining.

119. In fact, M.M. had not suffered the stated weight loss, did not have the stated signs and symptoms of aspiration with infection, and was not prescribed Levaquin during this period.

120. These falsified medical records for M.M. were provided to Medicare contractor Cahaba for its audit (Probe Edit). Medicare, through Cahaba, approved payment for all of the reviewed billings.

B. HCH, Pugman, Ganetsky, and Kolodesh Submitted Or Caused to Be Submitted False and Fraudulent Claims And False Records and Statements -- And Conspired to Get Such Claims Allowed Or Paid -- For Crisis Care

121. Medicare paid HCH for crisis care services that: (a) were not actually provided to HCH patients; (b) were inappropriately provided to HCH patients; or (c) were not medically necessary under the Medicare requirements, because the HCH patients were not in crisis during the periods that HCH claimed it provided crisis care. For these services, defendants HCH, Pugman, Ganetsky, and Kolodesh, from at least January 2003 to October 2008: (a) knowingly submitted or caused to be submitted false or fraudulent claims to Medicare; (b) created, submitted, or caused to be submitted documentation that falsely represented patient eligibility for crisis care; and (c) conspired with a common purpose to defraud the government by getting -- and, in fact, acted to get -- Medicare to pay false or fraudulent claims.

122. Defendants HCH, Pugman, Ganetsky, and Kolodesh disregarded Medicare regulations in order to increase HCH's Medicare reimbursement for crisis care services, which these defendants knew Medicare reimbursed at a higher level than the levels at which it reimbursed routine home care and other hospice services.

123. Defendant Pugman pleaded guilty to an Information charging him, in part, with conspiring with other persons, between January 2003 and October 2008, to defraud Medicare, by engaging in the following conduct:

> Defendant Alex Pugman, in order to increase HCH revenues, authorized the submission of claims to Medicare which defendant Pugman knew were false and fraudulent in that defendant Pugman represented: . . . (b) HCH patients received hospice services on the level of continuous care at the approximate rate of $800 per 24 hour period, when, in reality, approximately 90% of the continuous care level of hospice services were not provided and patients received hospice services consistent with only a routine level of care, for which HCH fraudulently obtained payments from Medicare totaling approximately $1,500,000.

124. Defendant Ganetsky pleaded guilty to an Information charging in part that:

> From in or around January 2003 to in or about October 2008, Alex Pugman, as the Director of HCH, authorized the submission of claims to Medicare which were false and fraudulent, in that: . . . (b) approximately 90% of the continuous care level of services billed at the rate of approximately $800 per 24 hour period was not provided, and patients instead received hospice services consistent with only a routine level of care which was reimbursed at a lower rate of approximately $140 per day, resulting in payments fraudulently obtained from Medicare totaling approximately $1,500,000.

125. As charged in the Information to which defendant Pugman pleaded guilty and the Indictment on which defendant Kolodesh was found guilty, during the relevant period, (a) defendant Kolodesh authorized defendant Pugman to direct, and (b) defendant Pugman, in

fact, directed and authorized, (c) HCH supervisors and nursing staff to fabricate nursing documentation (d) to support claims submitted by HCH to Medicare totaling approximately $1.5 million (e) for crisis care hospice services that were not provided to patients (f) but that were billed at the higher, more-costly crisis care rate of approximately $800 per 24-hour period.

126. As charged in the Information to which defendant Pugman pleaded guilty, during the relevant period defendant Pugman created "phony" schedules of HCH staff crisis care visits to hospice patients who did not qualify for crisis care and who were never provided this level of care. These schedules falsely reflected visits by HCH nurses and home health aides to patients within a 24-hour period, often for two-to-five day periods. In some instances, the "phony" schedules were created after patients died or were hospitalized, in order to reflect, fraudulently, that HCH provided crisis care services for days prior to the patient's death or hospitalization.

127. As charged in the Information to which defendant Pugman pleaded guilty, during the relevant period, defendant Pugman authorized and directed certain members of the HCH nursing staff, nursing supervisors and home health aides to coordinate the fabrication of the nursing notes of these patient visits to support the fraudulent claims for crisis care services. In some instances, individuals who were not trained as home health aides were authorized to document care that was falsely described as crisis care. Defendant Pugman paid the nursing staff participating in the crisis care scheme approximately $20 to $25 for every hour a nurse claimed to have provided the crisis care, as reflected in the fabricated nursing notes. Participating home health aides were paid the sum of approximately $11 per hour for every hour falsely claimed to reflect the provision of crisis care.

Examples of False Claims for Crisis Care Services[12]

128. Defendants HCH, Pugman, Ganetsky, and Kolodesh knowingly submitted or caused to be submitted false or fraudulent crisis care claims to Medicare -- and conspired to defraud the government by getting false or fraudulent claims to Medicare paid -- for the following patients, and Medicare paid for those claims.

Patient W.W.

129. HCH, Pugman, Ganetsky, and Kolodesh knowingly submitted or caused to be submitted false or fraudulent claims to Medicare -- and conspired to defraud the government by getting false or fraudulent claims to Medicare paid -- for four days of crisis care between June 17, 2007 at 10 a.m. and June 21, 2007 at 12:00 a.m. (86 hours) for patient W.W. Patient W.W. died on June 21, 2007 after being diagnosed with end-stage bladder cancer and supposedly receiving hospice care at his home. These claims were false or fraudulent because W.W. had not received crisis care immediately before his death, between June 17 and 21, 2007.

130. Testimony from former HCH Office Manager Cecelia Wiley evidences that: (a) defendant Pugman was aware that W.W. died on June 21, 2007 and had not received crisis care between June 17 and 21, 2007; but (b) after W.W.'s death, defendant Pugman nevertheless altered or created -- or directed that HCH staff alter or create, and HCH staff then altered or created -- HCH records to reflect, falsely, that W.W. had received 86 hours of crisis care between

[12] To protect patient privacy, the United States has identified only by initials, not full names, individual patients who, by way of example, the False Claims Act defendants knew were not eligible for crisis care -- or were not provided crisis care -- that was billed by HCH to Medicare. The United States will serve defendants with a list identifying each patient by name and patient identification number. The United States notes that the patients identified by their initials in these examples were also identified by the same initials in the indictment of defendant Kolodesh on two counts of mail fraud, in violation of 18 U.S.C. § 1341. Defendant Kolodesh was convicted on those charges, among others.

June 17 and 21, 2007, when, in fact, he had not received crisis care during that period but, rather, had received at most only HCH-administered routine home care services at his home.

131. Defendants HCH, Pugman, Ganetsky, and Kolodesh knowingly submitted or caused the submission of false or fraudulent claims numbered 20717001529904 and 20718700554804 to Medicare -- and conspired to defraud the government by getting those false or fraudulent claims to Medicare paid -- for purported crisis care services for patient W.W. that were not provided, for the period June 17, 2007 to June 21, 2007, in the amount of $3,354.42. Medicare paid the claims in the amount of $3,354.85.

Patient E.R.

132. HCH, Pugman, Ganetsky, and Kolodesh knowingly submitted or caused to be submitted false or fraudulent claims to Medicare – and conspired to defraud the government by getting false or fraudulent claims to Medicare paid – for three days (72 hours) of crisis care, between 2:00 p.m. on January 23, 2007 and 2:00 p.m. on January 26, 2007, for patient E.R., who was diagnosed with end-stage coronary artery disease and received hospice care at her home.

133. E.R.'s HCH nurse, Eugenia Roytenberg, R.N., testified that, between January 23 and 26, 2007, E.R. was not in crisis and did not require continuous nursing care to palliate acute symptoms. Roytenberg further testified that HCH records were nevertheless falsified, at the direction of defendant Ganetsky, to state that E.R. was in crisis during this period.

134. Nurse Roytenberg further testified that defendant Ganetsky told her that the reason E.R. was placed on crisis care during this time was that if E.R. had been scheduled for routine home care, then Roytenberg would not have been able to visit E.R.'s home each day between January 23 and 26, 2007. But Ganetsky wanted Roytenberg, on each of those days, to

visit E.R.'s "really sick" son (who lived with E.R. and was also an HCH patient, on Medicaid). Defendant Ganetsky therefore directed that E.R. be placed on crisis care so that Medicare-reimbursable visits to the home would occur on each of those days. Although as a result E.R. was placed on crisis care, and Roytenberg visited the home daily during the period, neither Roytenberg nor any other HCH nurse provided continuous care to E.R. between January 23 and 26, 2007 .

135. Defendants HCH, Pugman, Ganetsky, and Kolodesh knowingly submitted or caused the submission of a false or fraudulent claim numbered 20705400522504 to Medicare -- and conspired to defraud the government by getting that false or fraudulent claim to Medicare paid -- for crisis care services for patient E.R. that were not necessary or not provided for the period January 23, 2007 to January 26, 2007, in the amount of $2,563.20. Medicare paid that claim in the amount of $2,563.56.

Patient N.N.

136. HCH, Pugman, Ganetsky, and Kolodesh knowingly submitted or caused to be submitted false or fraudulent claims to Medicare -- and conspired to defraud the government by getting false or fraudulent claims to Medicare paid -- for approximately 40 hours of crisis care, between May 31, 2008 and June 1, 2008, for patient N.N., who was diagnosed with end-stage congestive heart failure and who received hospice care at her residence. These claims were false or fraudulent because, as defendant Ganetsky testified, the claimed crisis care, in fact, was not provided. Ganetsky further testified that Pugman and she authorized HCH to bill Medicare for this never-provided crisis care.

137. Defendants HCH, Pugman, Ganetsky, and Kolodesh knowingly submitted or caused the submission of false or fraudulent claims numbered 20817000165604 and 20817000170804 to Medicare -- and conspired to defraud the government by getting those false or fraudulent claims to Medicare paid -- for crisis care services for patient N.N. that were not provided for the period May 31, 2008 to June 1, 2008, in the amount of $1,470.40. Medicare paid the claims in the amount of $1,470.38.

FIRST CAUSE OF ACTION
(False or Fraudulent Claims)
(Against Defendants HCH, Pugman, Ganetsky, and Kolodesh)
(False Claims Act, 31 U.S.C. § 3729(a)(1)) (2006)[13]

138. The United States re-alleges and incorporates by reference the allegations of paragraphs 1 through 137.

139. By virtue of the acts described above, defendants HCH, Pugman, Ganetsky, and Kolodesh presented or caused to be presented to an officer or employee of the United States false or fraudulent Medicare claims for payment or approval, in violation of the False Claims Act, 31 U.S.C. § 3729(a)(1)(2006). That is, these defendants knowingly made or presented, or caused to be made or presented, to the United States claims for: (a) payment for hospice services for patients who were not eligible in whole or part for Medicare hospice benefits; and (b) medically unnecessary services or services that were not provided or were inappropriate.

140. By reason of the foregoing, the United States suffered actual damages in an amount to be determined at trial and is therefore entitled to treble damages under the False Claims Act, plus civil penalties of not less than $5,500 and not more than $11,000 per false

[13] The at-issue conduct occurred before enactment of the Fraud Enforcement and Recovery Act of 2009 ("FERA") on May 20, 2009. Therefore, pre-FERA Section 3729(a)(1) applies.

claim. Pursuant to the Federal Civil Penalties Inflation Act of 1990, as amended by the Debt Collection Improvement Act of 1996, 28 U.S.C. § 2461 (notes), and 64 Fed. Reg. 47099, 47103 (1999), civil penalties were adjusted to $5,500 to $11,000 for violations occurring on or after September 29, 1999.

SECOND CAUSE OF ACTION
(False Records/Statements)
(Against Defendants HCH, Pugman, Ganetsky, and Kolodesh)
(False Claims Act, 31 U.S.C. § 3729(a)(1)(B) (2010)[14]

141. The United States re-alleges and incorporates by reference the allegations of paragraphs 1 through 140.

142. By virtue of the acts described above, defendants HCH, Pugman, Ganetsky, and Kolodesh knowingly made, used, or caused to be made or used false records or statements material to false or fraudulent Medicare claims, in violation of the False Claims Act, 31 U.S.C. § 3729(a)(1)(B) (2010). That is, these defendants knowingly made or used or caused to be made or used false Medicare claim forms and supporting materials, such as internal billing forms, and false certifications of the truthfulness and accuracy of claims submitted, to get false or fraudulent Medicare claims paid or approved by the United States, in that the hospice services claimed were for: (a) patients who were not eligible in whole or in part for Medicare hospice benefits; and (b) medically unnecessary services or services that were not provided or were inappropriate.

143. By reason of the foregoing, the United States suffered actual damages in an amount to be determined at trial, and therefore is entitled to treble damages under the False Claims Act, plus civil penalties of not less than $5,500 and not more than $11,000 per false claim. Pursuant to the Federal Civil Penalties Inflation Act of 1990, as amended by the Debt

[14] Although the at-issue conduct occurred before the enactment of FERA in May 2009, Section 3729(a)(1)(B) under FERA applies retroactively to that conduct.

Collection Improvement Act of 1996, 28 U.S.C. § 2461 (notes), and 64 Fed. Reg. 47099, 47103 (1999), civil penalties were adjusted to $5,500 to $11,000 for violations occurring on or after September 29, 1999.

THIRD CAUSE OF ACTION
(Conspiracy)
(Against Defendants HCH, Pugman, Ganetsky, and Kolodesh)
(False Claims Act, 31 U.S.C. § 3729(a)(3) (2006))[15]

144. The United States re-alleges and incorporates by reference the allegations of paragraphs 1 through 143.

145. By virtue of the acts described above, defendants HCH, Pugman, Ganetsky, and Kolodesh conspired to defraud the United States by getting false or fraudulent Medicare claims allowed or paid by the United States, in violation of the False Claims Act, 31 U.S.C. § 3729(a)(3)(2006). That is, these defendants conspired to get such claims allowed or paid for hospice services for patients who were not eligible in whole or in part for Medicare hospice benefits, and for medically unnecessary services or services that were not provided or were inappropriate.

146. By reason of the foregoing, the United States suffered actual damages in an amount to be determined at trial, and therefore is entitled to treble damages under the False Claims Act, plus civil penalties of not less than $5,500 and not more than $11,000. Pursuant to the Federal Civil Penalties Inflation Act of 1990, as amended by the Debt Collection Improvement Act of 1996, 28 U.S.C. § 2461 (notes), and 64 Fed. Reg. 47099, 47103 (1999),

[15] The at-issue conduct occurred before enactment of FERA on May 20, 2009. Therefore, pre-FERA Section 3729(a)(3) applies.

civil penalties were adjusted to $5,500 to $11,000 for violations occurring on or after September 29, 1999.

FOURTH CAUSE OF ACTION
(Unjust Enrichment)
(Against Defendants HCH, Pugman, Ganetsky, Kolodesh, and Yakobashvili)

147. The United States re-alleges and incorporates by reference the allegations of paragraphs 1 through 146.

148. This is a claim for recovery of monies by which defendants HCH, Pugman, Ganetsky, Kolodesh, and Yakobashvili have been unjustly enriched.

149. By virtue of the conduct and the acts described above, defendants HCH, Pugman, Ganetsky, Kolodesh, and Yakobashvili were unjustly enriched at the expense of the United States in an amount to be determined, which, under the circumstances, in equity and good conscience, should be returned to the United States.

PRAYER FOR RELIEF

WHEREFORE, the United States of America demands and prays that judgment be entered in its favor as follows:

a. As to the First, Second, and Third Causes of Action (False Claims Act), against defendants HCH, Pugman, Ganetsky, and Kolodesh, for: (i) statutory damages in an amount to be established at trial, trebled as required by law, and such penalties as are required by law; (ii) the costs of this action, plus interest, as provided by law; and (iii) any other relief that this Court deems appropriate, to be determined at a trial by jury.

b. As to the Fourth Cause of Action (Unjust Enrichment), for: (i) an amount equal to the money paid by the United States through the Medicare Program to HCH, or the amount by which HCH, Pugman, Ganetsky, Kolodesh, and Yakobashvili were unjustly enriched, plus interest; (ii) the costs of this action, plus interest, as provided by law; and (iii) any other relief that this Court deems appropriate, to be determined at a trial by jury. And

c. For all other and further relief as the Court may deem just and proper.

The United States hereby demands a jury trial on all claims alleged herein.

Date: May 21, 2014

Respectfully submitted,

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VERIFICATION

I, Matthew Hirschy, am a Special Agent for the United States Department of Health and Human Services assigned to the investigation of this matter. I verify, under penalty of perjury, that the facts in the Verified Complaint of the United States are true and correct to the best of my knowledge as of the May 21, 2014 date of filing of the Verified Complaint, and are based upon information obtained by me and other law enforcement agents during an investigation conducted by those agents and by me, in my capacity as a Special Agent of the United States Department of Health and Human Services.

5/21/2014

MATTHEW HIRSCHY
SPECIAL AGENT
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

CERTIFICATE OF SERVICE

I hereby certify that today, May 21, 2014, I filed the foregoing "United States' Verified Complaint Pursuant to 31 U.S.C. § 3731(c)" with the Clerk of Court in hard copy format, which upon the Clerk's docketing of the Complaint on the Court's CM/ECF system, will cause notice of such filing to be sent to counsel of record in this action that has been pending since 2006, and I further certify that, today, I caused the Complaint to be mailed by First-class United States mail to the following:

Steven F. Marino, Esquire
David H. Conroy, Esquire
Marino & Conroy
301 Wharton Street
Philadelphia, PA 19147

Dated: May 21, 2014

Gerald B. Sullivan
Assistant United States Attorney