22-0530-cv

United States Court of Appeals

for the

Second Circuit

JANE DOE 1, JANE DOE 2, SW CHALLENGER, LLC,

Plaintiffs-Appellants,

ABC, STATE OF TENNESSEE, STATE OF FLORIDA, STATE OF TEXAS, STATE OF NEW JERSEY, STATE OF ILLINOIS, STATE OF NORTH CAROLINA, STATE OF CONNECTICUT, STATE OF LOUISIANA, STATE OF NEW YORK, STATE OF NEW MEXICO, STATE OF ALASKA, STATE OF OKLAHOMA, STATE OF MONTANA, STATE OF CALIFORNIA, STATE OF MICHIGAN, STATE OF WASHINGTON, UNITED STATES OF AMERICA ex rel. SW CHALLENGER, LLC,

Plaintiffs,

– v. –

EVICORE HEALTHCARE MSI, LLC.,

Defendant-Appellee,

DEF, WELLCARE HEALTH PLANS INC.,

Defendants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

APPENDIX

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TABLE OF CONTENTS

CLOSED,APPEAL,ECF

U.S. District Court
Southern District of New York (Foley Square)
CIVIL DOCKET FOR CASE #: 1:19-cv-02501-VM

United States of America ex rel SW Challenger, LLC. v. Evicore Healthcare MSI, LLC.
Assigned to: Judge Victor Marrero
Cause: 31:3729 False Claims Act

Date Filed: 03/20/2019
Date Terminated: 02/10/2022
Jury Demand: Plaintiff
Nature of Suit: 375 Other Statutes: False Claims Act
Jurisdiction: U.S. Government Plaintiff

Plaintiff

ABC
TERMINATED: 06/10/2020

Plaintiff

United States Of America
ex rel. SW CHALLENGER, LLC

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Plaintiff

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Plaintiff

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SW Challenger, LLC

represented by **SW Challenger, LLC**
PRO SE

V.

Defendant

DEF
TERMINATED: 06/10/2020

Defendant

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Defendant

WellCare Health Plans Inc.

Date Filed	#	Docket Text
03/20/2019		Magistrate Judge James L. Cott is so designated. Pursuant to 28 U.S.C. Section 636(c) and Fed. R. Civ. P. 73(b)(1) parties are notified that they may consent to proceed before a United States Magistrate Judge. Parties who wish to consent may access the necessary form at the following link: http://nysd.uscourts.gov/forms.php. (rz) (Entered: 03/21/2019)
03/21/2019	1	SEALED DOCUMENT placed in vault.(rz) (Entered: 03/21/2019)
05/21/2019	2	SEALED DOCUMENT placed in vault.(rz) (Entered: 05/21/2019)
12/09/2019	3	SEALED DOCUMENT placed in vault.(rz) (Entered: 12/09/2019)
01/28/2020	4	SEALED DOCUMENT placed in vault.(rz) (Entered: 01/28/2020)
05/21/2020	5	SEALED DOCUMENT placed in vault..(dn) (Entered: 05/21/2020)
06/10/2020	6	ORDER, The Clerk of Court is directed to unseal the above-captioned case. SO ORDERED, (Signed by Judge Victor Marrero on 06/10/2020) (dn) (Entered: 06/11/2020)
06/10/2020	7	FIRST AMENDED COMPLAINT FOR VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT, 31 U.S.C. § 3729, ET SEQ. against Evicore Healthcare MSI, LLC. with JURY DEMAND. Document filed by United States Of America. (rro) Modified on 6/17/2020 (rro). ***This document was previously filed under seal in envelope #5 and unsealed by docket entry 6.*** (Entered: 06/17/2020)
06/10/2020	36	COMPLAINT against Evicore Healthcare MSI, LLC., WellCare Health Plans Inc.. Document filed by State of North Carolina, State of Louisiana, State of Oklahoma, State of Washington, State of Alaska, United States Of America, State of Illinois, State of Tennessee, State of Michigan, State of California, State of Florida, State of New Mexico, State of New Jersey, State of Montana, State Of Connecticut, State of Texas, State of New York. (***This document previously filed under seal in envelope. no. 1, unsealed by doc. no. 6).(js) (Entered: 02/12/2021)
08/27/2020	8	REQUEST FOR ISSUANCE OF SUMMONS as to Evicore Healthcare MSI, LLC, re: 7 Amended Complaint,. Document filed by United States Of America..(Stone, David) (Entered: 08/27/2020)
08/28/2020	9	ELECTRONIC SUMMONS ISSUED as to Evicore Healthcare MSI, LLC...(sj) (Entered: 08/28/2020)
09/09/2020	10	ENDORSED LETTER: addressed to Judge Victor Marrero from Stephen A. Weiss dated 9/8/2020 re: Accordingly, we are seeking leave of Court for a two week extension on the current September 8, 2020 deadline for service of process. On or before September 22, 2020 (hopefully well before), we intend to file the Motion to Amend the FAC with either a publicly filed or under seal SAC based upon the guidance provided by the Medicaid States. This will avoid the need for the parties to litigate a FAC that is intended to be superseded thus saving both parties and, more importantly, the Court time and expense. ENDORSEMENT: The request for extension is granted. So Ordered. (Service due by 9/22/2020.) (Signed by Judge Victor Marrero on 9/9/2020) (js) (Entered: 09/10/2020)

09/22/2020	11	MOTION to Amend/Correct -*Plaintiff's Motion to Further Amend Plaintiff's First Amended Complaint*. Document filed by United States Of America..(Weiss, Stephen) (Entered: 09/22/2020)
09/22/2020	12	MEMORANDUM OF LAW in Support re: 11 MOTION to Amend/Correct -*Plaintiff's Motion to Further Amend Plaintiff's First Amended Complaint*. . Document filed by United States Of America. (Attachments: # 1 Exhibit 1).(Weiss, Stephen) (Entered: 09/22/2020)
09/22/2020	13	PROPOSED ORDER. Document filed by United States Of America. Related Document Number: 11 ..(Weiss, Stephen) **Proposed Order to be reviewed by Clerk's Office staff.** (Entered: 09/22/2020)
09/22/2020		***NOTICE TO COURT REGARDING PROPOSED ORDER. Document No. 13 Proposed Order was reviewed and approved as to form. (km)** (Entered: 09/22/2020)
09/23/2020	14	ORDER granting 11 Motion to Amend/Correct. WHEREAS, Plaintiff (the "Movant") has moved by Notice of Motion supported by Movant's Brief for an order, pursuant to Fed. R. Civ. P. 15(a)(2), granting leave for Plaintiff, SW Challenger, LLC (SW Challenger"), to: 1) Further Amend the First Amended Complaint Upon consideration of Movant's motion and supporting papers, all responsive submissions thereto, and all other materials submitted to the Court, it is hereby: ORDERED, that SW Challenger may: 1) File a Second Amended Complaint. So Ordered. (Signed by Judge Victor Marrero on 9/23/2020) (js) (Entered: 09/23/2020)
09/23/2020	15	SECOND AMENDED COMPLAINT amending 7 Amended Complaint, against Evicore Healthcare MSI, LLC. with JURY DEMAND.Document filed by United States Of America, Jane Doe 1, State of Tennessee, State of Florida, State of Texas, State of New Jersey, Jane Doe 2, State of Illinois, State of North Carolina, State Of Connecticut, State of Louisiana, State of New York, State of New Mexico, State of Alaska, State of Oklahoma, State of Montana, State of California, State of Michigan, State of Washington. Related document: 7 Amended Complaint,..(Weiss, Stephen) (Entered: 09/23/2020)
11/12/2020	16	NOTICE OF APPEARANCE by David Mark Siegal on behalf of Evicore Healthcare MSI, LLC...(Siegal, David) (Entered: 11/12/2020)
11/12/2020	17	LETTER addressed to Judge Victor Marrero from David M. Siegal dated November 12, 2020 re: Pre-letter motion. Document filed by Evicore Healthcare MSI, LLC...(Siegal, David) (Entered: 11/12/2020)
11/19/2020	18	LETTER addressed to Judge Victor Marrero from Stephen A. Weiss dated November 19, 2020 re: Response to November 12, 2020 Pre-letter motion. Document filed by ABC, Jane Doe 1, Jane Doe 2, State Of Connecticut, State of Alaska, State of California, State of Florida, State of Illinois, State of Louisiana, State of Michigan, State of Montana, State of New Jersey, State of New Mexico, State of New York, State of North Carolina, State of Oklahoma, State of Tennessee, State of Texas, State of Washington, United States Of America..(Weiss, Stephen) (Entered: 11/19/2020)
11/20/2020	19	LETTER addressed to Judge Victor Marrero from David M. Siegal dated November 20, 2020 re: Counsel writes pursuant to Rule II.B.2 of your Honors Rules to explain why, after completion of the procedures contemplated in Rule. Document filed by Evicore Healthcare MSI, LLC...(Siegal, David) (Entered: 11/20/2020)
11/23/2020	20	RULE 7.1 CORPORATE DISCLOSURE STATEMENT. Identifying Corporate Parent CIGNA Corporation, Corporate Parent Evernorth Health, Inc. for Evicore Healthcare MSI, LLC.. Document filed by Evicore Healthcare MSI, LLC...(Siegal, David) (Entered: 11/23/2020)

11/23/2020	21	MOTION to Dismiss *Second Amended Complaint against eviCore*. Document filed by Evicore Healthcare MSI, LLC...(Siegal, David) (Entered: 11/23/2020)
11/23/2020	22	MEMORANDUM OF LAW in Support re: 21 MOTION to Dismiss *Second Amended Complaint against eviCore*. . Document filed by Evicore Healthcare MSI, LLC...(Siegal, David) (Entered: 11/23/2020)
12/07/2020	23	PROPOSED STIPULATION AND ORDER. Document filed by Jane Doe 1, Jane Doe 2, United States Of America..(Weiss, Stephen) (Entered: 12/07/2020)
12/08/2020	24	ORDER AND STIPULATED MOTION SETTING BRIEFING SCHEDULE: NOW, THEREFORE IT IS HEREBY STIPULATED AND AGREED among Relators and Defendant that: 1.Relators shall have until January 22, 2021 to file their Opposition to Defendant's Motion to Dismiss Second Amended Complaint and 2. Defendant shall have until February 12, 2020 to file its Reply brief. IT IS SO ORDERED., (Responses due by 1/22/2021, Replies due by 2/12/2021.) (Signed by Judge Victor Marrero on 12/08/2020) (ama) (Entered: 12/08/2020)
12/11/2020	25	MOTION for Laurence J. Freedman to Appear Pro Hac Vice ANYSDC-22999320 receipt $200.00 . **Motion and supporting papers to be reviewed by Clerk's Office staff.** Document filed by Evicore Healthcare MSI, LLC.. (Attachments: # 1 Declaration of Laurence J. Freedman, # 2 Exhibit A- Certificated of Good Standing, # 3 Exhibit B- Certificate of Good Standing, # 4 Text of Proposed Order).(Freedman, Laurence) Modified on 12/11/2020 (bcu). (Entered: 12/11/2020)
12/11/2020		**>>>NOTICE REGARDING PRO HAC VICE MOTION. Regarding Document No. 25 MOTION for Laurence J. Freedman to Appear Pro Hac Vice . Motion and supporting papers to be reviewed by Clerk's Office staff.. The document has been reviewed and there are no deficiencies. (bcu)** (Entered: 12/11/2020)
12/11/2020	26	MOTION for Brian P. Dunphy to Appear Pro Hac Vice . Filing fee $ 200.00, receipt number ANYSDC-23000236. **Motion and supporting papers to be reviewed by Clerk's Office staff.** Document filed by Evicore Healthcare MSI, LLC.. (Attachments: # 1 Declaration of Brian P. Dunphy, # 2 Exhibit A- Certificated of Good Standing, # 3 Text of Proposed Order).(Dunphy, Brian) (Entered: 12/11/2020)
12/11/2020	27	MOTION for Nicole E. Henry to Appear Pro Hac Vice . **Motion and supporting papers to be reviewed by Clerk's Office staff.** Document filed by Evicore Healthcare MSI, LLC.. (Attachments: # 1 Declaration of Nicole E. Henry, # 2 Exhibit A- Certificated of Good Standing, # 3 Text of Proposed Order).(Siegal, David)Receipt No. ANYSDC-23000915 $200 Modified on 12/14/2020 (vba). (Entered: 12/11/2020)
12/14/2020		**>>>NOTICE REGARDING PRO HAC VICE MOTION. Regarding Document No. 26 MOTION for Brian P. Dunphy to Appear Pro Hac Vice . Filing fee $ 200.00, receipt number ANYSDC-23000236. Motion and supporting papers to be reviewed by Clerk's Office staff.. The document has been reviewed and there are no deficiencies. (vba)** (Entered: 12/14/2020)
12/14/2020		**>>>NOTICE REGARDING PRO HAC VICE MOTION. Regarding Document No. 27 MOTION for Nicole E. Henry to Appear Pro Hac Vice . Motion and supporting papers to be reviewed by Clerk's Office staff.. The document has been reviewed and there are no deficiencies. (vba)** (Entered: 12/14/2020)
12/14/2020	28	ORDER FOR ADMISSION PRO HAC VICE; granting 26 Motion for Brian P. Dunphy to Appear Pro Hac Vice. So Ordered. (Signed by Judge Victor Marrero on 12/14/2020) (js) (Entered: 12/14/2020)
12/15/2020	29	ORDER FOR ADMISSION PRO HAC VICE: granting 27 Motion for Nicole E. Henry to

		Appear Pro Hac Vice. So Ordered. (Signed by Judge Victor Marrero on 12/15/2020) (js) (Entered: 12/15/2020)
12/15/2020	30	NOTICE OF APPEARANCE by Nicole E. Henry on behalf of Evicore Healthcare MSI, LLC...(Henry, Nicole) (Entered: 12/15/2020)
01/22/2021	31	MEMORANDUM OF LAW in Opposition re: 21 MOTION to Dismiss *Second Amended Complaint against eviCore*. . Document filed by ABC, Jane Doe 1, Jane Doe 2, State Of Connecticut, State of Alaska, State of California, State of Florida, State of Illinois, State of Louisiana, State of Michigan, State of Montana, State of New Jersey, State of New Mexico, State of New York, State of North Carolina, State of Oklahoma, State of Tennessee, State of Texas, State of Washington, United States Of America..(Weiss, Stephen) (Entered: 01/22/2021)
01/28/2021	32	LETTER addressed to Judge Victor Marrero from Laurence J. Freedman dated January 28, 2021 re: Pre-Motion Letter to Unseal. Document filed by Evicore Healthcare MSI, LLC...(Freedman, Laurence) (Entered: 01/28/2021)
02/04/2021	33	LETTER MOTION for Extension of Time to File *a Statement of Interest* addressed to Judge Victor Marrero from Li Yu dated 2/4/2021. Document filed by United States Of America..(Yu, Li) (Entered: 02/04/2021)
02/05/2021	34	ORDER granting 33 Letter Motion for Extension of Time to File. The request at Dkt. No. 33 is granted. The Government may submit a statement of interest by 2/22/21. Defendant's reply is hereby extended to 3/15/21. So Ordered. (Signed by Judge Victor Marrero on 2/5/2021) (js) (Entered: 02/05/2021)
02/05/2021		Set/Reset Deadlines: Replies due by 3/15/2021. (js) (Entered: 02/05/2021)
02/08/2021	35	ORDER: On January 28, 2021, the defendant in the above captioned matter filed an unopposed letter request to unseal the Complaint and "any notice of declination filed by the U.S. Attorney's Office." (See Dkt. No. 32.) The Court hereby GRANTS the request. The Clerk of Court is directed to unseal the Complaint in the above-captioned case (see Dkt. No. 1), and enter the attached declination letter into the public docket. SO ORDERED. (Signed by Judge Victor Marrero on 2/8/2021) (ks) Transmission to Sealed Records Clerk for processing. (Entered: 02/09/2021)
02/15/2021	37	LETTER MOTION for Extension of Time to File *Statement of Interest and Reply* addressed to Judge Victor Marrero from Li Yu dated 2/15/2021. Document filed by United States Of America..(Yu, Li) (Entered: 02/15/2021)
02/16/2021	38	ORDER: granting 37 Letter Motion for Extension of Time to File. The request for extension is granted. The Government's deadline to file its statement of interest is extended until March 1, 2021. Defendant's deadline to respond is extended until March 22, 2021. So Ordered. (Signed by Judge Victor Marrero on 2/16/2021) (js) (Entered: 02/16/2021)
02/16/2021		Set/Reset Deadlines: Responses due by 3/22/2021 (js) (Entered: 02/16/2021)
03/01/2021	39	RESPONSE to Motion re: 21 MOTION to Dismiss *Second Amended Complaint against eviCore*. *Statement of Interest of the United States*. Document filed by United States Of America..(Yu, Li) (Entered: 03/01/2021)
03/11/2021	40	LETTER MOTION for Extension of Time *for eviCore to file its reply brief in connection with its pending motion to dismiss and its response to the Governments Statement of Interest* addressed to Judge Victor Marrero from David M. Siegal dated March 11, 2021., LETTER MOTION for Leave to File Excess Pages *EviCore also requests permission to file a combined reply brief and response to the Statement of Interest of up to five*

		additional pages addressed to Judge Victor Marrero from David M. Siegal dated March 11, 2021. Document filed by Evicore Healthcare MSI, LLC...(Siegal, David) (Entered: 03/11/2021)
03/12/2021	41	ORDER granting 40 Letter Motion for Extension of Time; granting 40 Letter Motion for Leave to File Excess Pages. The requests are granted. Defendant eviCore is authorized to file a combined memorandum of law of up to 15 pages. The deadline to do s is hereby extended from 3/22/21 to 4/12/21. So Ordered. (Signed by Judge Victor Marrero on 3/12/2021) (js) (Entered: 03/12/2021)
03/12/2021		Set/Reset Deadlines: Responses due by 4/12/2021 Replies due by 4/12/2021. (js) (Entered: 03/12/2021)
04/12/2021	42	REPLY MEMORANDUM OF LAW in Support re: 21 MOTION to Dismiss *Second Amended Complaint against eviCore. and Response to the United States' Statement of Interest [Dkt. No. 39]*. Document filed by Evicore Healthcare MSI, LLC...(Siegal, David) (Entered: 04/12/2021)
05/03/2021	43	ORDER FOR ADMISSION PRO HAC VICE granting 25 Motion for Laurence J. Freedman to Appear Pro Hac Vice. (Signed by Judge Victor Marrero on 5/3/2021) (nb) (Entered: 05/03/2021)
08/13/2021	44	DECISION AND ORDER granting 21 Motion to Dismiss For the reasons set forth above, it is hereby ORDERED that the motion of defendant eviCore Healthcare MSI to dismiss the Second Amended Complaint of plaintiffs United States of America ex rel. SW Challenger, LLC ("Relators') (Dkt. No. 21) is GRANTED and Relators' claims are dismissed without prejudice. So Ordered.. (Signed by Judge Victor Marrero on 8/13/2021) (js) Transmission to Orders and Judgments Clerk for processing. (Entered: 08/16/2021)
01/31/2022	45	ORDER: IT IS HEREBY ORDERED that within seven (7) days, the parties shall provide the Court with an update on the status of this litigation and the contemplation of any further proceedings. In the event no timely response to this Order is submitted, the Court may dismiss the action without further notice for lack of prosecution. SO ORDERED. (Signed by Judge Victor Marrero on 1/31/2022) (js) (Entered: 01/31/2022)
02/07/2022	46	LETTER addressed to Judge Victor Marrero from Stephen Weiss dated 02/07/2022 re: Status Report. Document filed by ABC, Jane Doe 1, Jane Doe 2, State Of Connecticut, State of Alaska, State of California, State of Florida, State of Illinois, State of Louisiana, State of Michigan, State of Montana, State of New Jersey, State of New Mexico, State of New York, State of North Carolina, State of Oklahoma, State of Tennessee, State of Texas, State of Washington, United States Of America..(Weiss, Stephen) (Entered: 02/07/2022)
02/07/2022	47	LETTER addressed to Judge Victor Marrero from David M. Siegal dated February 7, 2022 re: Status Report. Document filed by Evicore Healthcare MSI, LLC...(Siegal, David) (Entered: 02/07/2022)
02/08/2022	48	ORDER re: 44 Order on Motion to Dismiss. IT IS HEREBY ORDERED, in accordance with the Court's August 13, 2021, Decision and Order (Dkt. No. 44), the Clerk of Court is directed to terminate all pending motions and enter final judgment in favor of eviCore Healthcare MSI, LLC. SO ORDERED. (Signed by Judge Victor Marrero on 2/8/2022) (kv) Transmission to Orders and Judgments Clerk for processing. (Entered: 02/08/2022)
02/10/2022	49	CLERK'S JUDGMENT re: 48 Order in favor of Evicore Healthcare MSI, LLC. against State Of Connecticut, State of Alaska, State of California, State of Florida, State of Illinois, State of Louisiana, State of Michigan, State of Montana, State of New Jersey,

		State of New Mexico, State of New York, State of North Carolina, State of Oklahoma, State of Tennessee, State of Texas, State of Washington, United States Of America. It is hereby ORDERED, ADJUDGED AND DECREED: That for the reasons stated in the Court's Order dated February 8, 2022, the Court granted defendant eviCore Healthcare MSI, LLC's motion to dismiss the Second Amended Complaint (SAC) from plaintiff relator SW Challenger, LLC, on behalf of the United States and several individual states. The Court granted leave for the Relators to further amend the SAC. On February 7, 2022, Relators notified the Court they do not intend to replead and request final judgment be entered so they may effectuate an appeal. In accordance with the Court's August 13, 2021, Decision and Order, final judgment is entered in favor of eviCore Healthcare MSI, LLC. (Signed by Clerk of Court Ruby Krajick on 2/10/2022) (Attachments: # 1 Right to Appeal) (km) (Entered: 02/10/2022)
03/14/2022	50	NOTICE OF APPEAL from 49 Clerk's Judgment,,,,. Document filed by Jane Doe 1, Jane Doe 2, SW Challenger, LLC. Form C and Form D are due within 14 days to the Court of Appeals, Second Circuit..(Weiss, Stephen) Modified on 3/14/2022 (nd). (Entered: 03/14/2022)
03/14/2022		Appeal Fee Due: for 50 Notice of Appeal.$505.00 Appeal fee due by 3/28/2022..(nd) (Entered: 03/14/2022)
03/14/2022		Transmission of Notice of Appeal and Certified Copy of Docket Sheet to US Court of Appeals re: 50 Notice of Appeal..(nd) (Entered: 03/14/2022)
03/14/2022		Appeal Record Sent to USCA (Electronic File). Certified Indexed record on Appeal Electronic Files for 50 Notice of Appeal filed by Jane Doe 1, SW Challenger, LLC, Jane Doe 2 were transmitted to the U.S. Court of Appeals..(nd) (Entered: 03/14/2022)
03/15/2022		Appeal Fee Payment: for 50 Notice of Appeal. Filing fee $ 505.00, receipt number ANYSDC-25862239..(Weiss, Stephen) (Entered: 03/15/2022)

PACER Service Center			
Transaction Receipt			
07/07/2022 11:10:16			
PACER Login:	cpnycpara16	**Client Code:**	
Description:	Docket Report	**Search Criteria:**	1:19-cv-02501-VM
Billable Pages:	9	**Cost:**	0.90

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA; and the STATE OF ALASKA, the STATE OF CONNECTICUT, the STATE OF FLORIDA, the STATE OF ILLINOIS, the STATE OF LOUISIANA, the STATE OF MICHIGAN, the STATE OF MONTANA, the STATE OF NEW JERSEY, the STATE OF NEW MEXICO, the STATE OF NEW YORK, the STATE OF NORTH CAROLINA, the STATE OF OKLAHOMA, the STATE OF TENNESSEE, the STATE OF TEXAS, and the STATE OF WASHINGTON, *ex rel.* [UNDER SEAL], Plaintiffs, vs. [UNDER SEAL], Defendant.	Case No. --------- JURY TRIAL DEMANDED **COMPLAINT FOR VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT, 31 U.S.C. § 3729, *ET SEQ.* AND STATE LAW COUNTERPARTS** **UNDER SEAL** **Pursuant to 31 U.S.C. § 3730(b)(2)**

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA; and
the STATE OF ALASKA,
the STATE OF CONNECTICUT,
the STATE OF FLORIDA,
the STATE OF ILLINOIS,
the STATE OF LOUISIANA,
the STATE OF MICHIGAN,
the STATE OF MONTANA,
the STATE OF NEW JERSEY,
the STATE OF NEW MEXICO,
the STATE OF NEW YORK,
the STATE OF NORTH CAROLINA,
the STATE OF OKLAHOMA,
the STATE OF TENNESSEE,
the STATE OF TEXAS, and
the STATE OF WASHINGTON,

ex rel. SW CHALLENGER, LLC,

Plaintiffs,

vs.

EVICORE HEALTHCARE MSI, LLC, and
WELLCARE HEALTH PLANS, INC.,

Defendants.

Case No. ---------

JURY TRIAL DEMANDED

COMPLAINT FOR VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT, 31 U.S.C. § 3729, *ET SEQ.* AND STATE LAW COUNTERPARTS

UNDER SEAL
Pursuant to 31 U.S.C. § 3730(b)(2)

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Plaintiff, SW Challenger, LLC ("SW Challenger"), on behalf of the United States of America (the "United States") and the States of Alaska, Connecticut, Florida, Illinois, Louisiana, Michigan, Montana, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Tennessee, Texas, and Washington, (collectively, the "Qui Tam States"), brings this action pursuant to the Qui Tam provisions of the Federal Civil False Claims Act, 31 U.S.C. §§ 3729, *et seq.*, as amended (the "Federal False Claims Act"), and the Qui Tam States' statutes as enumerated below, against eviCore Healthcare MSI, LLC ("eviCore") and WellCare Health Plans, Inc. ("WellCare"). In support thereof, SW Challenger alleges as follows:

I. INTRODUCTION

1. This is an action to recover damages and civil penalties on behalf of the United States and the Qui Tam States arising from false and/or fraudulent records, statements and claims made, used or presented and/or caused to be made, used or presented by Defendants and/or their agents or employees under the Federal False Claims Act and the Qui Tam States' statutes.

2. Medicare, Medicaid, and other government programs, including CHIP and EPSDT, as well as private insurance carriers, only cover and reimburse medical services which are medically "reasonable and necessary." 42 U.S.C. § 1395y(a)(1). Medicaid's coverage and reimbursement for medical services is based upon a determination of "medical necessity."

3. In some contexts, providers request prior authorization for the provision of a medical service. Prior authorization requests must be reviewed to determine whether the services requested are medically reasonable and necessary.

4. In administering government-funded healthcare insurance programs, managed care organizations ("MCOs"), such as WellCare, Passport, Blue Cross Blue Shield ("BCBS"), the Health Care Service Corporation ("HCSC"), Health Alliance Medical Plan ("HAMP"), and Moda

Health, are required to perform certain functions, including those related to prior authorization and utilization management and payment processing for outpatient and home health services. MCOs may subcontract with third parties, like Defendant eviCore, to perform these functions for the MCO under the government contracts.

5. eviCore is in the business of providing utilization management services to determine medical necessity for Medicare and Medicaid programs for outpatient and home health services. eviCore contracts with private insurance companies, *i.e.*, MCOs, to provide utilization management services and review prior authorization requests for medical necessity.

6. As relevant here, eviCore's contracts with MCOs, including its contracts with WellCare, include a key timing provision that requires eviCore to approve, partially approve, or deny in a timely fashion each request for prior authorization to deem services to a given beneficiary as medically reasonable and necessary (each request also referred to as a "case"). In many instances, the turnaround time ("TAT") to process requests for prior authorizations is only 24 to 48 hours. Failure to meet its prescribed TAT will result in contractual penalties for eviCore.

7. Since at least November 2016, Defendant eviCore has engaged in fraudulent activities involving its role as the gatekeeper for determining whether requested services are medically reasonable and necessary. As detailed herein, in compliance with directives from WellCare to approve certain services regardless of medical necessity, and in independent efforts to keep up with the high volume of prior authorization requests for services and to avoid contractual TAT penalties, eviCore instituted a scheme simply to "auto-approve" hundreds of cases on a daily basis, reflexively deeming those services as reasonable and necessary, even though there had been no appropriate medical necessity evaluation of those cases, and in some cases, no actual human evaluation of those cases whatsoever.

8. eviCore specifically directed its qualified medical personnel, internally called "Clinical Reviewers," including Relators, to "auto-approve" or "approve as requested" services in specific jurisdictions, for specific populations, and/or under specific healthcare plans, before and without any review of the medical reasonableness and necessity of the services.

9. These auto-approve directives, as described by eviCore to its reviewers, included, at various times, (i) directives to Clinical Reviewers to "auto-approve" certain categories of services without any review; and (ii) directives to use an "all-or-nothing" approach to approving requests of services, instead of approving only those portions of the request that the Clinical Reviewer deemed medically reasonable and necessary.

10. Upon information and belief, certain auto-approval and all-or-nothing directives were implemented with the knowledge of or at the express direction of MCOs, such as WellCare, HCSC, HAMP, and Moda, and certain other directives were implemented by eviCore independently.

11. In addition to the directives eviCore provided to its Clinical Reviewers, eviCore took further steps to ensure the approval of certain categories of requests by designing and implementing a data analytics system called "CorePath" that automatically approved certain requests in the absence of any human review.

12. As a result of eviCore's fraudulent conduct, the government programs have been paying and continue to pay billions of dollars for services which have not been properly deemed medically reasonable and necessary.

13. Defendants knew, or were reckless in not knowing, that their conduct, as described herein, would lead to the submission and payment of claims for reimbursement by government

healthcare programs for services that were not medically reasonable or necessary and thus, were not eligible for reimbursement.

14. But for Defendants' illegal conduct, those services would not have been approved nor reimbursed.

15. As a result, Defendants have caused, and continue to cause, the submission of billions of dollars of false claims to government programs, and Defendants have benefited from the payment of those false claims.

II. JURISDICTION AND VENUE

16. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. §§ 1331 and 1345 and 31 U.S.C. §§ 3730 and 3732(a). The Court has original jurisdiction over the State law claims pursuant to 31 U.S.C. § 3732(b) because this action is brought under State laws for the recovery of funds paid by the Qui Tam States and arises from the same transactions or occurrences brought on behalf of the United States under 31 U.S.C. § 3730.

17. This Court has personal jurisdiction over the Defendants because, among other things, the Defendants transact business in this judicial district, and engaged in wrongdoing in this judicial district.

18. Venue is proper in this judicial district under 31 U.S.C. § 3732(a) and 28 U.S.C. §§ 1391(b) and (c). Defendants transact business within this judicial district, and acts proscribed by 31 U.S.C. § 3729 occurred in this judicial district.

19. Pursuant to 31 U.S.C. § 3730(b)(2), along with this Complaint, SW Challenger prepared and has served on the Attorney General of the United States, the United States Attorney for the Southern District of New York, and the Attorneys General of the Qui Tam States written disclosures of all material evidence and information currently in its possession.

20. This action is not based upon prior public disclosure of allegations or transactions in a federal criminal, civil, or administrative hearing, in which the government or its agent is a party. Nor have SW Challenger's allegations or transactions herein been publicly disclosed in a congressional, Government Accountability Office, or other federal report, hearing, audit, or investigation; or in news media; or in any other form as the term "publicly disclosed" is defined in 31 U.S.C. § 3730(e)(4)(A) and parallel provisions of the Qui Tam States' statutes.

21. To the extent there has been a public disclosure unknown to Relators of any of the allegations herein, Relators are the original source of those allegations within the meaning of 31 U.S.C. § 3730(e)(4)(B) and parallel provisions of the Qui Tam States' statutes.

III. PARTIES

A. Plaintiffs

22. Plaintiff SW Challenger, a Delaware Limited Liability Company, brings this action on behalf of itself, the United States of America and the Qui Tam States named herein. Its principal place of business is c/o Seeger Weiss LLP, 55 Challenger Road, Ridgefield Park, NJ 07660. Among the members of SW Challenger are current eviCore employees (referred to herein collectively as "Relators" and individually as "Relator #1" and "Relator #2") with personal knowledge of the fraudulent scheme alleged in this Complaint. The Relators possess personal knowledge and experience regarding eviCore's "auto-approve" activities, including personal contact with the employees and executives of eviCore who have planned, initiated and directed the violations of law alleged herein. The personal knowledge of SW Challenger is not distinct from that of the Relators.

23. Relators #1 and #2 are employed by eviCore as Clinical Reviewers, whose primary job responsibilities include reviewing physical therapy and occupational therapy treatment requests to determine medical necessity in the prior authorization context.

24. Relators' personal knowledge of Defendants' illegal conduct is supported by their own personal investigation undertaken to further develop and substantiate the allegations set forth in this Complaint.

25. Plaintiff, the United States of America, acting through the Department of Health and Human Services ("HHS"), and its Centers for Medicare and Medicaid Services, administers the Health Insurance Program for the Aged and Disabled established by Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.* ("Medicare"), and Grants to States for Medical Assistance Programs pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, *et seq.* ("Medicaid").

26. Plaintiffs Qui Tam States participate in the Medicaid program and have State False Claims Acts which permit private persons, such as Relators, to sue on their behalf to recover for false and fraudulent claims submitted for payment by Medicaid programs and/or other government healthcare programs.

B. Defendant eviCore

27. Defendant eviCore is a Tennessee limited liability company with its principal place of business located at 400 Buckwalter Place Boulevard, Bluffton, South Carolina 29910.

28. eviCore is a direct successor to CareCore National ("CareCore"). In 2014, CareCore merged with MedSolutions, Inc., and the resulting entity rebranded itself as eviCore in 2015.

29. Between 2007 and 2013, CareCore engaged in Medicaid and Medicare fraud on a national scale, in which, as the Department of Justice reported, CareCore "blindly approved

hundreds of thousands of medical procedures over a period of many years, leaving Medicare and Medicaid to foot the bill."[1] From 2007 to 2013, CareCore improperly authorized over 200,000 outpatient diagnostic procedures, and, in 2017, paid a $54 million settlement based on that conduct. At least half of eviCore's current executive leadership team, including eviCore's Chief Executive Officer, were also in management positions at CareCore during the period 2007 to 2013.

30. As set forth in detail below, eviCore has continued its fraudulent scheme to overbill government health care programs.

31. Like its predecessor CareCore, eviCore contracts with private healthcare insurance companies to provide prior authorization and utilization management services pertaining to home health and outpatient services ordered by treating providers for the insurers' patient-beneficiaries.

32. Many of eviCore's private insurer clients are also carrier contractors under Medicare and state Medicaid programs, as well as for other government healthcare programs. Thus, eviCore provides prior authorization for services that are ordered for Medicare, Medicaid and other government program patient-beneficiaries, many of which, as alleged herein, did not qualify as "covered services," yet were ultimately paid for by those programs.

33. eviCore employs a total of seventy-nine Physical Therapy ("PT"), Occupational Therapy ("OT"), and Speech Therapy ("SLP") Clinical Reviewers, of whom only thirteen are assigned to the review of pediatric therapy cases.

C. Defendant WellCare

34. Defendant WellCare is a Delaware corporation with its principal place of business located at 8735 Henderson Road, Tampa, FL 33634.

[1] Acting U.S. Attorney Announces $54 Million Settlement of Civil Fraud Lawsuit Against Benefits Management Company for Improper Authorization Of Medical Procedures, (2017), https://www.justice.gov/usao-sdny/pr/acting-us-attorney-announces-54-million-settlement-civil-fraud-lawsuit-against-benefits.

a. WellCare operates through its affiliates located throughout the country, and, directly or through its affiliates, has contracted with subcontractors of Centers for Medicare and Medicaid Services and/or Centers for Medicare and Medicaid Services itself, in connection with administering Medicare claims in various states, including Arkansas, Florida, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, New Jersey, New York, Ohio, South Carolina, and Texas.

b. WellCare, directly or through its affiliates, has contracted with the States of Arkansas, Florida, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, New Jersey, New York, Ohio, South Carolina, and Texas, or their subcontractors, in connection with administering Medicaid claims in those states.

c. WellCare, directly or through its affiliates, has contracted with eviCore in connection with requests for prior authorization and utilization management services for Medicare and Medicaid beneficiaries.

35. In 2009, WellCare entered into a Deferred Prosecution Agreement and paid $40 million in restitution stemming from its falsification of patient data and its retention of Medicaid funds that should have been returned to Florida Medicaid, primarily through falsely inflating expenditure information it submitted to Florida Medicaid. On April 26, 2011, WellCare entered into a five-year Corporate Integrity Agreement with the Department of Health and Human Services based upon the same conduct. In 2012, WellCare paid a further $137.5 million to the federal government and the states of Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Missouri, New York and Ohio to resolve actions based upon the same conduct.

36. WellCare and other MCOs contracted, directly or indirectly, with one or more federal and/or state government programs to provide, *inter alia*, utilization management services for outpatient and home health procedures ordered for government program beneficiaries.

37. MCOs contracted, directly or indirectly, with eviCore.

38. MCOs delegated to eviCore the duty to make prior authorization medical necessity decisions on home health and outpatient services, certain of which eviCore and MCOs knew would result in payment/reimbursement by government programs for those services that were approved for government program beneficiaries.

39. MCOs, including WellCare, directed certain of eviCore's auto-approval schemes, and therefore had actual knowledge of those schemes. As alleged herein, MCOs including WellCare, HCSC, BCBS, HAMP, and Moda failed to conduct proper audits of eviCore's services. Proper audits of eviCore's services by the MCOs would have revealed eviCore's fraudulent schemes to auto-approve medical necessity determinations.

IV. LEGAL AND REGULATORY FRAMEWORK

A. The False Claims Act

40. The False Claims Act, 31 U.S.C. § 3729, as amended, provides:

> (a) **Liability for certain acts** –
>
> (1) In general – Subject to paragraph (2), any person who –
>
> (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; [or]
>
> (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
>
> * * *
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the

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

31 U.S.C. § 3729(a)(l).

41. "Knowingly" is defined by the False Claims Act as "mean[ing] that a person, with respect to information—(i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information…." 31 U.S.C. § 3729(b)(1)(A).

42. Given its remedial purposes, the False Claims Act is interpreted broadly, and is "intended to reach all types of fraud, without qualification, that might result in financial loss to the Government." *United States v. Neifert-White Co.*, 390 U.S. 228, 232 (1968).

43. The False Claims Act empowers a private person having information regarding a false or fraudulent claim against the Government to bring an action on the Government's behalf and to share in any recovery. 31 U.S.C. § 3730. The complaint must be filed under seal without service on the defendant. *Id.* The complaint remains under seal to give the Government an opportunity to conduct an investigation into the allegations and to determine whether to join the action. *Id.*

44. Each of the Qui Tam States has adopted a False Claims Act that provides comparable relief to those states for the submission of false and fraudulent claims. These include:

a. Alaska : ALASKA STAT. § 09.58.010, *et seq.*;

b. Connecticut: CONN. GEN. STAT. § 4-277, *et seq.*;

c. Florida: FLA. STAT. ANN. § 68.081, *et seq.*;

d. Illinois: 740 ILL. COMP. STAT. ANN. 175/1, *et seq.*;

e. Louisiana: LA. REV. STAT. ANN. § 46:437.1, *et seq.*;

f. Michigan: MICH. COMP. LAWS ANN. § 400.601, *et seq.*;

g. Montana: MONT. CODE ANN. § 17-8-401, *et seq.*;

h. New Jersey: N.J. STAT. ANN. § 2A:32C-1, *et seq.*;

i. New Mexico: N.M. STAT. ANN. § 27-14-1, *et seq.*;

j. New York: N.Y. STATE FIN. LAW § 187, *et seq.*;

k. North Carolina: N.C. GEN. STAT. § 1-605, *et seq.*;

l. Oklahoma: OKLA. STAT. ANN. tit. 63, § 5053, *et seq.*;

m. Tennessee: TENN. CODE ANN. §71-5-181, *et seq.*;

n. Texas: TEX. HUM. RES. CODE ANN. § 36.001, *et seq.*;

o. Washington: WASH. REV. CODE § 74.66.005, *et seq.*;

45. Pursuant to the federal False Claims Act and the Qui Tam States' statutes, the Relators seek to recover, on behalf of the United States and the Qui Tam States, damages and civil penalties arising from the submission of false or fraudulent claims supported by false or misleading statements that the Defendants caused to be submitted for payments, and that Defendants knew or should have known were going to be paid ultimately by government healthcare programs, including the Medicare, Medicaid, and other government-funded programs.

B. Medicare

46. Title XVIII of the Social Security Act, 42 U.S.C. § 1395, *et seq.*, establishes the federal Medicare health insurance program for the elderly and disabled. Medicare operates by authorizing payments for inpatient and outpatient healthcare services to "providers," such as hospitals, skilled nursing facilities, outpatient rehabilitation facilities, and home health agencies. 42 U.S.C. §§ 1395cc(a), 1395x(u).

47. The Centers for Medicare and Medicaid Services administers Medicare on behalf of the Secretary.

48. For all services and items, Medicare coverage is limited to services that are medically "reasonable and necessary." 42 U.S.C. § 1395y(a)(1).

49. Although "reasonable and necessary" is not defined in the Act, Congress has vested final authority in the Secretary to determine what items or services are "reasonable and necessary." *See* 42 U.S.C. § 1395ff(a); *Heckler v. Ringer*, 466 U.S. 602, 617 (1984).

50. "A private physician's word on medical necessity is not dispositive." *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). *See also Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003) ("[C]ourts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant's physician; nor may courts impose on administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation.").

51. Pursuant to Section 1874A of the Social Security Act, Medicare may contract with eligible entities, including MCOs, to perform certain functions or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities), *see* 42 U.S.C. § 1395kk-1(a), such as payment functions (including the function of developing local coverage determinations, as defined in section 1395ff(f)(2)(B)), provider services functions, and functions relating to services furnished to individuals entitled to benefits under Medicare part A or enrolled under Medicare part B of, or both, as follows:

> (A) Determination of payment amounts.—Determining (subject to the provisions of section 1395oo of this title and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this subchapter to be made to providers of services, suppliers and individuals.
>
> (B) Making payments.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).
>
> (C) Beneficiary education and assistance.—Providing education and outreach to individuals entitled to benefits under part A or enrolled under part B, or both, and

> providing assistance to those individuals with specific issues, concerns, or problems.
>
> (D) Provider consultative services.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this subchapter and otherwise to qualify as providers of services or suppliers.
>
> (E) Communication with providers.—Communicating to providers of services and suppliers any information or instructions furnished to the medicare administrative contractor by the Secretary, and facilitating communication between such providers and suppliers and the Secretary.
>
> (F) Provider education and technical assistance.—Performing the functions relating to provider education, training, and technical assistance.
>
> (G) Improper payment outreach and education program.—Having in place an improper payment outreach and education program described in subsection (h).
>
> (H) Additional functions.—Performing such other functions, including (subject to paragraph (5)) functions under the Medicare Integrity Program under section 1395ddd of this title, as are necessary to carry out the purposes of this subchapter.

42 U.S.C. § 1395kk-1(a)(4).

52. As provided for in practice guidelines promulgated by HHS, individual states must ensure, through their contracts, that each MCO adopt guidelines that are based on valid and reliable clinical evidence of a particular field of practice. *See* 42 C.F.R. § 438.236. For example, the Agency for Health Care Administration, the Florida division that administers Medicaid, defines medical necessity with reference to the following statement: "services furnished or ordered must be individualized, specific and consistent with the condition under treatment, and not in excess of the member's needs and must be consistent with generally accepted professional medical standards." FLA. ADMIN. CODE ANN. r. 59G-1.010. Such guidelines are in place based on Early and Periodic Screening Diagnosis and Treatment (EPSDT) mandates for states that use of federal monies for Medicaid programs.

53. Carrier contractors, including MCOs, are obligated to perform functions under the Medicare Integrity Program, 42 U.S.C. § 1395kk-1(a), which include any or all program integrity functions described in 42 C.F.R. § 421.304, which include "(a) [c]onducting medical reviews, utilization reviews, and reviews of potential fraud related to activities of providers of services…" and "(b) [a]uditing, settling and determining cost report payments for providers of services, or other individuals or entities. . . as necessary to help ensure proper Medicare payment." *See also* 42 C.F.R. § 421.200 (specifying carrier contractor functions).

54. Carrier contractors are required to "identify and verify potential errors to produce the greatest protection to the Medicare program." Medicare Program Integrity Manual § 2.1B.

55. In addition, carrier contractors, including MCOs, are "responsible for deterring and detecting fraud and abuse." Centers for Medicare and Medicaid Services Medicare Administrative Contractor Statement of Work § C.5.13.

C. Medicaid

56. The Medicaid Program, as enacted by Title XIX of the Social Security Act of 1965, 42 U.S.C. § 1396, *et seq.*, is a joint federal-state program that provides health care benefits for certain groups, primarily indigent and disabled individuals.

57. This cooperative federal-state Medicaid program directs federal funding to participating states to provide medical assistance to "families with dependent children and of aged, blind and disabled individuals, whose income and resources are insufficient to meet the costs of ***necessary*** medical services." 42 U.S.C. § 1396-1 (emphasis added).

58. The federal portion of each state's Medicaid payments, known as the Federal Medical Assistance Percentage ("FMAP"), is based on a state's per capita income compared to the national average. 42 U.S.C. § 1396d(b).

59. The Medicaid statute requires each participating state to implement and administer a state plan for medical assistance services which contains certain specified minimum criteria for coverage and payment of claims. 42 U.S.C. §§ 1396, 1396a(a)(10).

60. To prevent Medicaid from paying for unnecessary services, 42 U.S.C. § 1396a(a)(30)(A) requires states to maintain "methods and procedures" to "safeguard against unnecessary utilization" of Medicaid care and services.

61. Although the standard of "medical necessity" is not explicitly denoted in the Medicaid Act, it has become a judicially accepted component of the federal legislative scheme. *See, e.g., Beal v. Doe*, 432 U.S. 438, 444 (1977).

62. It is consistent with Medicaid objectives "for a State to refuse to fund *unnecessary* – though perhaps desirable – medical services." *Beal*, 432 U.S. at 444-45 (emphasis in original).

63. Each state can limit Medicaid services, if it chooses, to meet a state-created definition of medical necessity. *See* 42 C.F.R. § 440.230(d) ("The [Medicaid] agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.").

64. Many states have further defined medical necessity related to coverage under Medicaid by state statute, code or other regulatory provision.

65. Further, state Medicaid agencies are required to perform audits to implement a Statewide surveillance and utilization control program:

> The Medicaid agency must implement a statewide surveillance and utilization control program that—
>
> (a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;
>
> (b) Assesses the quality of those services;

> (c) Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part; and
>
> (d) Provides for the control of the utilization of inpatient services in accordance with subparts C through I of this part.

42 C.F.R. § 456.3.

66. As with Medicare, state Medicaid agencies can delegate their duties to private insurance carrier contractors, including MCOs, with which they also contract to administer health plans under state Medicaid managed care programs. *See* 42 C.F.R. § 434.6. Those delegated duties may include the determination as to whether services requested by a provider are medically necessary and appropriate.

67. In addition to the above, the Qui Tam States have enacted state Medicaid laws or regulations governing, among other things, medical necessity, program quality assurance/auditing functions of carrier contractors, and subcontractor requirements. These include:

a. Alaska

   i. ALASKA STAT. § 21.07.250(18) (medical necessity);

   ii. ALASKA STAT. § 21.07.020 (required contract provisions for managed care plans).

b. Connecticut:

   i. CONN. GEN. STAT. § 17b-259b (medical necessity);

   ii. Conn. Gen. Stat. § 17b-28b (contracting);

   iii. CONN. GEN. STAT. § 17b-267 (quality assurance/auditing).

c. Florida:

   i. FLA. ADMIN. CODE ANN. r. 59G-1.010(166) (medical necessity);

   ii. FLA. ADMIN. CODE ANN. r. 59G-8.100(9) (quality assurance/auditing); and

   iii. FLA. ADMIN. CODE ANN. r. 59G-8.100(2)(c), Fla. Admin. Code Ann. r. 59G-8.100(13) (subcontractor requirements).

d. Illinois:

i. 215 ILL. COMP. STAT. 105/2; ILL. ADMIN. CODE, tit. 89, § 140.2 (medical necessity); and

ii. 215 ILL. COMP. STAT. 134/80 (quality assurance/auditing).

e. Louisiana:

i. LA. ADMIN. CODE tit. 50, pt. I, § 1101 (medical necessity definition and criteria);

ii. LA. REV. STAT. ANN. §§ 40:2211, 40:2221 (contracting); and

iii. LA. ADMIN. CODE tit. 50, pt. I, § 3305 (contracting and utilization management).

f. Michigan:

i. MICH. COMP. LAWS ANN. § 400.111a (medical necessity);

ii. MICH. COMP. LAWS ANN. § 333.26368.III.A.12 (quality assurance/ auditing as to subcontractors' arrangements with Medicaid managed care companies); and

iii. MICH. COMP. LAWS ANN. § 333.26368.IV.H (ability to subcontract duties).

g. Montana:

i. MONT. CODE. ANN. § 53-6-101(9) (necessary medical services); MONT. ADMIN. R. 37.82.102(18) (medically necessary defined); and

ii. MONT. CODE ANN. § 53-6-705(8) (quality assurance required of managed care entity); MONT. ADMIN. R. 37.85.410 (designated review organization to determine medical necessity); MONT. ADMIN. R. 37.85.414(3) (designated review organization to perform quality control).

h. New Jersey:

i. N.J. STAT. ANN. § 30:4D-5 (medical necessity);

ii. N.J. STAT. ANN. § 30:4D-12; and Contract Template between NJ Department of Human Services and Medicaid Contractor, at p. 48, http://www.nj.gov/humanservices/dmahs/info/resources/care/hmo-contract.pdf. (quality assurance/auditing); and

iii. N.J. STAT. ANN. § 30:4D-7(p), (q), (r); N.J. STAT. ANN. § 30:4D-7b - 7c; N.J. STAT. ANN. § 30:4D-8; N.J. STAT. ANN. § 30:4D-9 (ability to subcontract duties).

i. New Mexico:

i. N.M. STAT. ANN. § 27-2-12.6 (medically necessary services); N.M. ADMIN. CODE tit. 8, § 300.1.9 (medically necessary) N.M. ADMIN. CODE tit. 8, § 301.5.9 (insuring recipients receive only necessary services);

ii. N.M. ADMIN. CODE tit. 8, § 302.5 (quality control, prior authorization and utilization review); and

iii. N.M. ADMIN. CODE tit. 8, § 300.6.9 (administration through contractors); and

iv. N.M. ADMIN. CODE tit. 8, § 302.2.10(E) (contractors).

j. New York:

i. N.Y. SOC. SERV. LAW § 365-a (medical necessity);

ii. N.Y. SOC. SERV. LAW § 364-j(8), N.Y. COMP. CODES R. & REGS. tit. 10, § 98-1.12 (quality assurance/auditing); and

iii. N.Y. COMP. CODES R. & REGS. tit. 10 § 98-1.11 (subcontractor requirements).

k. North Carolina:

i. N.C. GEN. STAT. § 108A-55(a) (necessary medical care); N.C. GEN. STAT. § 108C-7 (medical necessity criteria); N.C. ADMIN. CODE tit. 10A, r. 22F.0104; and

ii. N.C. ADMIN. CODE tit. 10A, r. 22A.0101 (fiscal agents under contract are required to conduct utilization reviews).

l. Oklahoma:

i. OKLA. STAT. tit. 56, § 1002(7) (necessary medical services); OKLA. STAT. tit. 56, § 1011.2 (medically necessary services); OKLA. ADMIN. CODE § 317:30-3-1(f) (medical necessity standards); and

ii. OKLA. STAT. tit. 56, § 1010.3 (contracting for claims administration).

m. Tennessee:

i. TENN. CODE ANN. § 71-5-144 (medical necessity);

ii. TENN. CODE ANN. § 71-5-130 (quality assurance/auditing and the authority to subcontract);

n. Texas:

i. 1 TEX. ADMIN. CODE § 353.2(57) (defining medical necessity);

ii. TEX. GOV'T CODE ANN. §§ 533.002, 533.005 (contracting); and

iii. 1 TEX. ADMIN. CODE § 353.417 (managed care quality assessment required).

o. Washington:

i. WASH. REV. CODE § 74.09.010 (10) (necessary medical services); WASH. ADMIN. CODE § 182-500-0085 (prior authorization requirement based upon medical necessity); and

ii. WASH. ADMIN. CODE § 182-538-063 (subcontracting).

V. EVICORE'S FRAUDULENT CONDUCT

A. Background on eviCore's Operations and Participation in Government Healthcare Programs

68. eviCore marketed, sold, and performed, and continues to market, sell, and perform, utilization management services to determine whether services that are covered and paid for by various government health insurance programs, including Medicare and Medicaid, are medically reasonable and necessary.

69. eviCore specifically contracts with third-party insurance companies, such as WellCare, to perform utilization management services by providing medical reasonableness and necessity determinations for services ordered by physicians and allied health professionals for hundreds of thousands of covered lives, including Medicare and Medicaid beneficiaries.

70. eviCore's Clinical Reviewers are trained in the use of utilization review criteria and rules provided to eviCore by MCOs (sometimes also referred to as the "Administrative Algorithm") to assess and to screen requests for prior authorization of evaluation and treatment procedures, which requests may have been processed previously by clerical intake department staff to collect demographic data. Clinical Reviewers consider the needs of individual patients and

characteristics of the local delivery system when applying the clinical criteria. eviCore's Clinical Reviewers have the authority to certify (*i.e.*, approve) requests when the clinical information provided is consistent with the utilization review criteria and standards of practice.

71. The various schemes described herein, under which eviCore provided prior authorization for services in the absence of medical necessity review, and in some cases with no review at all, not only violated eviCore's own internal policies and procedures, but, more importantly, resulted in the submission of false claims for payment of services that were not properly determined to be medically reasonable and necessary in violation of the reimbursement rules and regulations governing government healthcare programs.

72. All such false claims caused to be submitted by eviCore's fraudulent conduct violate the Federal False Claims Act and the Qui Tam States' statutes.

B. eviCore's Scheme – In Detail

1. Proper Prior Authorization Approvals and Denials

73. If (1) a treating provider decides that a patient requires services and (2) that patient is a beneficiary of one of the government programs that contracts with an MCO that in turn contracts with eviCore (or if the patient is a direct beneficiary of a private insurer that contracts with eviCore), then the provider or his/her office must communicate with eviCore to obtain prior authorization for the service in order to ensure that the costs of the services will be covered by the government program or private insurer.

74. This communication can be accomplished by telephoning eviCore, faxing eviCore, or using eviCore's website. Regardless of which method the provider pursues, the information is entered into a request management system maintained by eviCore, called "Image One." The Image One system prompts users – eviCore intake personnel, eviCore Clinical Reviewers, or the

providers themselves – to provide some of the points of demographic and clinical information necessary for eviCore to make medical necessity determinations.

75. In addition to "Image One," eviCore employs a data analytics system called "CorePath" to manage such requests. CorePath was created to automate prior authorization requests for a wide variety of populations, conditions and diagnoses. This automation is not based on valid and reliable clinical information and evidence-based clinical guidelines, but rather on criteria that do not meaningfully determine medical necessity, such as the number of visits at issue.

76. CorePath relies on insufficient clinical information in an effort to generate prior authorizations regardless of medical necessity.

77. The Image One system contains a "journal" field, which tracks the lifetime of the request in narrative form. In the context of cases "in auto-approval status," Clinical Reviewers are required to enter information into the journal explaining their approval, that either (i) does not meaningfully analyze the medical reasonableness or necessity of the request, or (ii) is itself fraudulent. MCOs, including WellCare, BCBS, HCSC, HAMP, and Moda, have the capability to access and review these journal entries.

78. When a provider uses the eviCore website to make a request, the provider himself/herself enters clinical information directly into CorePath.

79. When a prior authorization request comes in by telephone or fax and contains the information necessary to "build" the request in the CorePath system, the request is routed to intake department personnel. The intake department personnel, who are non-clinical clerks, use the information provided to "build" the request in the CorePath system in order to enable the system to generate a prior authorization decision.

80. When a prior authorization request comes in by telephone or fax and does not contain the information necessary to "build" the request in the CorePath system, the request is routed to Clinical Reviewers.

81. Under eviCore's legal and contractual obligations, after a request for a service for a beneficiary of Medicare or Medicaid is "built" in CorePath and/or Image One, eviCore Clinical Reviewers must review the request to determine whether the service is medically necessary before prior authorization will be approved. If the clinical information that was entered into Image One is insufficient for making such a determination, then Clinical Reviewers place the case on hold and request additional information necessary for their decision.

82. Instead of providing medical necessity review in all such cases, however, eviCore has devised a variety of interlocking schemes designed to ensure fast TAT, high rates of approval for requests, and low costs of review to eviCore – by sacrificing medical necessity review entirely in many categories of cases.

2. Directives to Manually Auto-Approve

83. One method by which eviCore reduces the time and money spent on medical necessity review is to direct Clinical Reviewers to ignore acceptable standards of clinical practice, evidence-based decision making, and their own clinical judgment, and to instead simply "auto-approve" all requests relating to certain providers, therapies, and populations.

84. Clinical Reviewers follow and implement these "auto-approve" directives by simply approving whatever services a provider requests, without making an independent determination on whether those services are medically necessary or reasonable.

85. These directives are relayed from eviCore management to Clinical Reviewers through training materials, emails, and conference calls.

86. In some cases, as set forth in further detail below, directives to "auto-approve" certain categories of requests originated from WellCare and were relayed to Clinical Reviewers by eviCore in order to maintain and further eviCore's relationships with WellCare.

87. In other cases, directives to "auto-approve" certain categories of requests originated from eviCore management. Even in the absence of any request from an MCO, eviCore is motivated to employ auto-approval procedures for a variety of reasons, including handling high volumes of requests, staff shortages, and tight TATs.

88. Upon information and belief, eviCore's contracts with insurers include key timing provisions that require eviCore to approve, partially approve, or deny provider requests within a limited time-period or pay a penalty for the late response.

89. Auto-approval also keeps review costs down by enabling eviCore to assign Clinical Reviewers to review cases outside of their scope of practice and licensure. Because cases "in auto-approval status" are to be approved regardless of medical necessity, eviCore is able to assign Clinical Reviewers to approve cases in fields in which they lack experience, knowledge, and licensure, making eviCore's staff more flexible. For example, on March 23, 2018, when eviCore was "short staffed on the [occupational therapy] side," Marysue Agostini, Manager of MusculoSkeletal ("MSK") Specialized Therapy, opened review of auto-approve occupational therapy requests to all pediatric physical therapy Clinical Reviewers. It is only the auto-approval system that makes it possible for eviCore to reassign staff in this way – the medical necessity review eviCore would otherwise employ would require special training and knowledge that auto-approval schemes do not require.

90. Reinforcing that "auto-approval" relieves the Clinical Reviewer of performing a medical necessity review, in an October 28, 2017 email, Agostini noted: "[A]ny Passport cases

with a start date of 11/1/17 or later requires medical necessity review. A start date of 10/31/17 or before remains auto approval."

91. eviCore internal documents also make clear that "auto-approval" is knowingly applied to cases for which medical necessity review is required.

92. In a document available on eviCore's internal Sharepoint server, titled "Developmental Pediatrics Concurrent / Prior Authorization Review Journal Templates," eviCore provides form journal entries to be used in CorePath for all cases "where medical necessity review is required." This document includes a section of "Statements for Developmental Pediatrics Auto-Approvals by Health Plan," which provides scripts for Clinical Reviewers to use in journal entries for the various categories of auto-approve cases, such as "Documentation shows needs for skilled care. Approved at the direction of the health plan," and even, simply, "Automated approval at the request of the health plan."

93. eviCore has actual knowledge not only of the fact that its auto-approve scheme in general does not comply with statutory requirements for medical necessity review, but also of many discrete examples where its "auto-approve" scheme led to inappropriate authorizations of services.

94. Agostini, in a November 8, 2017 email, herself described categories of cases that Clinical Reviewers "are auto approving that ask for significantly more visits than we would approve," and requested a set of "examples of egregious requests" to use in an upcoming meeting. Agostini specifically referenced in this email a case in which a Clinical Reviewer had "to auto approve 200 visits for an ankle sprain last week."

95. In a February 2019 email chain with subject "Wellcare FL CMS (Childrens Medical Services) Membership," a number of Clinical Reviewers expressed concern to Agostini regarding

the nature of the requests they were to auto-approve generally, and regarding specific improper requests.

96. One Clinical Reviewer noted to Agostini that "[t]he requests are far in excess of what we typically approve as far as frequency and duration." Another Clinical Reviewer wrote, "Some of the requests I had yesterday were awful. It is not appropriate for an older child with MD to receive 3 times per week for 6 months to work on strengthening by pushing the therapist's hands with their legs." Another identified further inappropriate requests, including requests for (i) therapy visits at four times per week over six months for a twelve-year-old who scores normal on standardized tests, but who the provider states, "based on clinical opinion has gross motor skills at 4 yo;" and (ii) therapy visits at three times a week over six months for a pediatric member who is able to run and jump, but who purportedly needed balance training.

97. In response to these concerns, including the specific inappropriate auto-approvals Clinical Reviewers identified, Agostini offered to, at a later date, "initiate a clinical discussion with Medical leadership at WellCare FL to discuss how best to approach the inappropriate therapy you are seeing. I expect that they will be adverse to denying care but should support a significant provider education effort." Agostini did not intervene to prevent the authorization of the identified cases, nor did she alter eviCore's previous directive to automatically approve these cases, which she herself identified as "inappropriate therapy."

98. Following this email traffic, in a February 13, 2019 call with Clinical Reviewers, Agostini stated: "I know it's a challenge for us to approve this level of care when what we're seeing is not supportive of what these providers are doing."

99. Upon information and belief, not only is WellCare aware that eviCore's role as "utilization manager" is a nullity, but WellCare in fact directed certain aspects of this scheme.

When asked on the February 13, 2019 call whether eviCore has "any plans to act as utilization managers" for Florida Medicaid pediatric patients, Agostini answered "I think eviCore would like to, but we have to follow the directives from the health plan."

100. As an example, a provider for WellCare Missouri Medicaid submitted a request for a fourteen-year-old female with amplified pain syndrome. The provider requested two-hour physical therapy sessions five days per week for a period of four weeks, and the same frequency and number of occupational therapy visits. The provider did not submit any clinical documentation regarding the physical therapy plan of care, did not provide the minimum of three functional and measurable therapy goals, and did not indicate that a less intense frequency of therapy had been attempted and was found ineffective. eviCore auto-approved the request in full based on its agreement with WellCare.

101. As another example, a provider for WellCare Medicaid Kentucky submitted a series of requests for non-surgical management of a thirteen-year-old boy who suffered a right elbow dislocation. Pursuant to the auto-approve scheme, eviCore approved a total of 56 physical therapy visits for this condition. Accepted standards of medical practice dictate a far smaller number of visits, and eviCore's own internal guidelines reflect six to fourteen visits as the accepted standard of practice.

102. eviCore, since at least November 2016, in accordance with its collusion with WellCare, has directed its Clinical Reviewers to "auto-approve" all requests for physical therapy and occupational therapy for Wellcare Medicare and Medicaid Florida WDD, WellCare Medicaid South Carolina, and WellCare Medicaid Kentucky. For cases where no specific number of visits was requested by the provider, and therefore the request could not be automatically approved, eviCore promulgated guidelines directing Clinical Reviewers to approve a set number of visits

based upon whether the request was an initial or subsequent request, whether the request was for a developmental or non-developmental condition, and the completeness of the information submitted by the provider.

103. eviCore, at various times since November 2016, has directed its Clinical Reviewers to "auto-approve" a set number of treatment visits for Medicare beneficiaries in response to requests from BCBS MI providers who have been classified as "Tier A" based upon their history of service utilization.

104. eviCore, at various times since June 2017, and continuously from October 2017 through February 2019, has directed its Clinical Reviewers to "auto-approve" all requests for treatment of pediatric developmental conditions from HCSC BCBS Texas Medicaid (classified by eviCore as "Alberto N. Cases").

105. eviCore, at various times since at least October 2017, in accordance with its collusion with WellCare, has directed its Clinical Reviewers to "auto-approve" all requests for treatment of developmental conditions in patients under twenty-one years of age for WellCare Medicaid Nebraska, Missouri, Kentucky, and South Carolina.

106. eviCore, from at least October 2017 to, directed its MSK Therapies Clinical Reviewers to "auto-approve" all Health Alliance Medical Plan Medicare cases in Washington and Illinois.

107. eviCore, since February 1, 2019, in accordance with its collusion with WellCare, has directed its Clinical Reviewers to "auto-approve" all pediatric requests for WellCare Medicaid Florida Children's Medical Service at the provider's requested visit frequency, for six months. Between February 1, 2019 and March 13, 2019, 11,000 requests from providers to eviCore and WellCare resulted in the approval of 124,000 visits for the period February 2019 to August 2019.

The average physical therapy request in Florida WellCare Medicaid was for thirty-two visits, compared to the national averages of 7 to 10 visits per physical therapy request. In the opinions of Relators, approximately the majority of automatically approved requests for WellCare Medicaid Florida Children's Medical Service do not meet the definition of medical necessity.

108. eviCore has, at various times since November 2016, also directed its Clinical Reviewers to "auto-approve" requests from Affinity Medicare and Medicaid NY, HCSC BCBSIL Medicaid, Passport Medicaid KY and WellCare Medicaid and Medicare plans, in order to enable eviCore to better manage the volume of requests under those plans.

109. eviCore has, at various times since November 2016, also directed its Clinical Reviewers to "auto-approve" Medicare requests from BCBS, Cambia, HAMP, and Moda, in states including, at least, Alaska, Idaho, Illinois, Michigan, New Mexico, Oklahoma, Oregon, Utah, Texas, and Washington.

3. CorePath and Image One

110. eviCore has also implemented artificial intelligence systems to further streamline the fraudulent auto-approve process.

111. The auto-approval schemes discussed above share a feature that makes them less efficient than they might be: Although each scheme prevents Clinical Reviewers from approving, partially approving, or denying cases based upon an independent determination of medical necessity, each scheme still requires a *de minimis* level of involvement from Clinical Reviewers, who must identify the request as involving a category "in auto-approval status," and then manually approve the request. The necessity of this human input makes it difficult for eviCore to scale up its review process and increase its geographical coverage range, number of covered lives, and market share.

112. To respond to this need, eviCore designed its data analytics system, CorePath. By empowering this automated system to determine whether to authorize a requested service, eviCore saves itself significant costs, avoids the risk of TAT penalties, and makes its utilization management services "scalable" – by sacrificing the medical necessity review it is obligated to perform.

113. In a phone call on September 14, 2017, Bruce Brownstein, eviCore's MSK Product Advisor, advised certain pediatric Clinical Reviewers that eviCore's expansion into new business lines would increase the number of requests submitted to eviCore to a point where it would be impossible for Clinical Reviewers making medical necessity determinations to keep up with the greater volume. Brownstein further advised that he was working on a CorePath AI process specific to pediatric occupational and physical therapy, which would automatically approve the first and second such requests from a provider without any clinical review. The first provider request in this context would be automatically approved. To design criteria to enable the AI to handle the second request from a provider in this context, Brownstein sought, and received, assistance from certain pediatric Clinical Reviewers.

114. In an October 26, 2017 email, Rocco Labbadia, eviCore Vice President for Clinical Content and Integration, circulated a document describing the CorePath system. This document stated that CorePath would require providers to respond only to a "limited set of clinical questions" during the request for care, and explained CorePath's main goals: "[i]t is a primary intention of CorePath to ***resolve a high majority of episodes of care without requiring any practitioner review*** or additional clinical information outside of the pathways" (emphasis added). CorePath would avoid practitioner review by mechanically approving services requests on its own: "The number of visits approved and date span of the approval will be based on algorithms that take into account

the clinical condition of the patient and are weighted by data analytics that describe the likely duration and intensity of appropriate care."

115. In a phone call on September 15, 2018, Labbadia represented that Brownstein's automated process for pediatric therapy requests was designed with the goal of making eviCore's utilization review "scalable," *i.e.*, to enable eviCore to pursue more business lines and secure a greater market share. Labbadia stated that pediatric therapy requests had been targeted by this program because of the longer review time associated with such requests.

116. In an email on February 6, 2019, Agostini advised pediatric Clinical Reviewers that eviCore was "working on programming so these cases," WellCare Florida Children's Medical Services cases, "will be approved up front and not come to review." On information and belief, this is because a combination of non-clinical intake agents and the CorePath AI are now auto-approving those requests.

117. For example, in one case involving a 21-year-old WellCare Nebraska Medicaid member with Rett's syndrome, a provider submitted a request through CorePath and received 104, hour-long physical therapy visits over a one-year period, to improperly treat a developmental condition. The provider supported the request with invalid test results, and listed certain goals.

118. The goals submitted by the provider were neither functional nor measurable, and the test results submitted by the provider in this case were not norm-referenced for a 21-year-old person. Further, eviCore review guidelines for WellCare dictate that approval periods be limited to a three-month duration. Last, because the member was over the age of 20, she was no longer eligible under Medicaid guidelines for rehabilitative therapy for a developmental condition.

119. Despite this incomplete and inaccurate clinical information, and the ineligibility of the patient, CorePath inappropriately approved the request in full, providing prior authorization for all 104, hour-long physical therapy visits over a one-year period.

120. Even in those cases where the CorePath AI does not independently make the final decision as to authorizing a requested treatment, the Image One software still restricts the ability of Clinical Reviewers to determine medical necessity by, *e.g.*, making it technically impossible for the Clinical Reviewer to deny, or partially deny, certain categories of requests.

121. For example, on September 6, 2017, Agostini notified the review team that she had identified a logic problem in the Image One system that needed to be addressed: With regard to WellCare Florida Medicaid cases, which were subject to an "auto-approve" directive at the time, "the system should be preventing us from making adverse determinations," *i.e.*, denials, "[h]owever, this is not happening."

122. Similarly, in a March 7, 2018 email implementing a different review process for certain categories of WellCare cases that had been subject to auto-approval, Agostini noted that the change "will require an IT update as the system does not allow for these cases to be denied."

123. As of March 2019, eviCore has implemented CorePath logic processes to automatically authorize requests from healthcare providers including Affinity, Blue Cross Blue Shield, Passport, and WellCare, across states including, at least, Arkansas, Connecticut, Illinois, Kentucky, Louisiana, Maine, Missouri, Mississippi, New Mexico, New York, North Carolina, Oklahoma, South Carolina, Tennessee, and Texas.

4. "All-Or-Nothing" Approvals

124. Beyond directing Clinical Reviewers to automatically approve certain categories of requests, eviCore also created other systems to authorize services that were not determined by a Clinical Reviewer to be medically reasonable and necessary, including "all-or-nothing" review.

125. Clinical Reviewers are instructed that when they see a request in Image One that is subject to "all-or-nothing" review, they are to make a binary decision between two actions: Authorize the request in full or deny it completely.

126. If a Clinical Reviewer determines that ***any*** part of a request subject to "all-or-nothing" review is medically reasonable or necessary, then the Clinical Reviewer is directed to approve the request in full, including not only those services the Clinical Reviewer determined were medically necessary, but also any other requested services that do not meet the requirements of medical necessity.

127. Clinical Reviewers are authorized to call the provider to attempt to negotiate in cases where the requested services went beyond what was medically necessary. But in a December 6, 2018 email, Vycki Rupakus, eviCore's Director of Provider Engagement Therapy, explained that if, on that call, the provider is "adamant about continued care, the request should be approved," regardless of the Clinical Reviewer's medical necessity determination.

128. For example, in the pediatric therapy context, a provider may request a number of visits with a therapist or a duration of treatment that is not supported by clinical information the provider submitted to eviCore. If a Clinical Reviewer determines that a lesser number of visits with a therapist than requested is medically reasonable and necessary, then the Clinical Reviewer is required by eviCore to approve the full number of medically unreasonable and unnecessary visits requested.

129. eviCore's "all-or-nothing" review was implemented in a March 7, 2018 email from Agostini to eviCore's Clinical Reviewers, and initially applied to all WellCare pediatric developmental requests that had been subject to the "auto-approval" directive at that time, including WellCare Kentucky, Florida, Nebraska, and Missouri.

130. In the March 7, 2018 email, Agostini communicated the substance of the "all-or-nothing" review process: "If there is a need for therapy, any request by the therapist should be approved (even if it is excessive)."

131. Agostini identified the new "all-or-nothing" review instruction as an "ask from WellCare."

132. Pursuant to Agostini's email, if a request included clinical information that showed a developmental delay was present, then the request for service had to be fully approved, regardless of the medical necessity or reasonableness of the requested service, or its relationship to the demonstrated developmental delay.

133. As an example, a provider for WellCare Kentucky Medicaid submitted a series of requests starting in November 2017 for a six-year-old boy with an unspecified developmental delay. eviCore received six requests for physical therapy and six requests for occupational therapy, and because these requests were governed by eviCore's "all-or-nothing" scheme, all of these requests were approved, for a total of 114 therapy visits in less than two years. The seventh request for physical therapy in this case was the first request to be reviewed by a Clinical Reviewer, the prior requests having been resolved – and granted – by the CorePath AI discussed *supra*. The seventh request for occupational therapy in this case was the first request to be reviewed by an occupational therapy clinical reviewer for medical necessity. However, despite the fact that requests in this case were finally being assigned to an appropriate Clinical Reviewer, eviCore's guidelines still mandated "all-or-nothing" review, causing the Clinical Review to approve requested services that went beyond medical necessity.

134. eviCore's "all-or-nothing" review process is incompatible with medical necessity review, and the application of the scheme makes it impossible to use the medical necessity guidelines outlined by CMS in determining prior authorization.

135. Categories of requests have been subject to "all-or-nothing" review at various times since March 2018 include, at least, all WellCare pediatric developmental requests in Florida, Kentucky, Missouri, and Nebraska.

C. eviCore's Medical Necessity Review, When Performed, is Itself Deficient to the Point of Fraud

136. Even when eviCore nominally reviewed provider requests for medical necessity, the processes eviCore employed failed to ensure the adequacy of the review and caused hundreds of thousands of false claims to be presented to the United States and the Qui Tam States.

137. eviCore routinely assigned Clinical Reviewers to review requests beyond the scope of the Clinical Reviewer's clinical expertise and licensure, without providing proper training to the Clinical Reviewer, and without meaningfully reviewing the accuracy of the non-specialist Clinical Reviewer's determinations.

138. For example, since at least November 2016, eviCore has assigned OT, PT, and SLP therapy reviewers to review requests across one another's disciplines, despite the fact that such requests are outside the clinical expertise and licensure of those Clinical Reviewers. In re-assigning non-specialist Clinical Reviewers, eviCore failed to meaningfully train Clinical Reviewers on how to apply medical necessity review guidelines in reviewing requests beyond the scope of their expertise and licensure. National organizations including the Utilization Review Accreditation Commission and the National Committee for Quality Assurance require that prior authorization determinations be made by specialists within their own discipline.

139. Criteria to establish a developmental delay that qualifies for skilled care services varies between states and managed care organizations. WellCare guidelines state that eligibility for therapy to address developmental delay is based on a norm-referenced standardized test score that falls 1.0 standard deviations or more below the mean in at least one subtest area of a composite score.

140. Under HCSC BCBS Texas Medicaid guidelines, eligibility for therapy is based on a score that falls 1.5 standard deviation or more below the mean in at least one subtest area of composite score on a norm-referenced standardized test. When a pediatric member's test score is less than 1.5 standard deviations below the mean, a criterion-referenced test along with informed evidenced-based clinical statements must be included to support the medical necessity of services. Measurable, functional, short- and long-term goals will be considered, along with test results. If a pediatric member cannot complete test assessment, documentation of the reason a standardized test score could not be used must also be reported. A functional description of the child's abilities and deficits must also be to Clinical Reviewers to determine medical necessity.

141. In a series of Wednesday conference calls for the purpose of training OT Clinical Reviewers on how to review PT requests, Agostini and Carrie Jordan, Manager of MSK Specialized Therapy, directed OT and PT Clinical Reviewers to consider standardized test scores for developmental pediatric cases as "guidelines," instead of as the determinative factors those tests are meant to be under state programs.

142. Further, as part of the same training, Agostini and Jordan directed OT and PT Clinical Reviewers to "round" scores in ways that led to increased approvals – for example, by deeming a score 1.47 standard deviations below the mean (which would make certain PT requests medically unnecessary under Texas guidelines) to "count as" a score 1.5 standard deviations below

the mean (which would make those same PT requests medically necessary under Texas guidelines).

143. Following this contentious team meeting in which Agostini and Jordan recommended that standardized test scores reported on pediatric prior authorization requests be used 'as a guideline' only, concern was raised by several Clinical Reviewers regarding this policy change which is inconsistent with accepted standards of pediatric physical therapy practice. Communication continued with Agostini following a pediatric team meeting on January 23, 2019. It was later reported that Laura Walters-Beitz, Director Clinical Services PT/OT/ST, Product Operations, had given direction to Agostini to uphold the previous review policy to regard standardized test scores as intended (*i.e.*, without rounding) in order to determine eligibility for therapy services.

144. Due to eviCore's failures in training and staffing, as illustrated above, eviCore's Clinical Reviewers are often not equipped to accurately determine the medical necessity of requests they review.

145. Although eviCore conducts monthly audits of the subset of requests its Clinical Reviewers actually review for medical necessity, eviCore's audit function is flawed in ways that complement its training and staffing deficiencies.

146. Despite the fact that monthly audits purport to require a score of 95% or better, failing Clinical Reviewers are allowed to continue without extra training, oversight, remediation or consequences for repeated poor scores.

147. eviCore does not adequately train its Clinical Reviewers to review requests from outside the Clinical Reviewer's specialty, despite assigning out-of-specialty cases to its Clinical Reviewers. Further, eviCore's audit function does not serve as an effective quality control

mechanism for its Clinical Reviewers' determinations. Through these failures, eviCore has caused the submission of false claims for reimbursement of services provided to Medicaid and Medicare beneficiaries.

D. eviCore's Attempts to Whitewash its Auto-Approval Schemes

148. In early February 2019, eviCore began a process of whitewashing its internal review materials to remove or obfuscate references to automatic approval. At every stage of this process, however, eviCore made it clear to Clinical Reviewers that the replacement of the "auto-approve" language with euphemisms was not intended as a substantive change to the auto-approve process, which eviCore directed its Clinical Reviewers to continue.

149. On February 22, 2019, Agostini emailed a small group of Clinical Reviewer supervisors, advising them that "we need to update our resources and remove any language of 'auto-approval,'" and providing substitute language, such as "approve as requested," and "approve up to the benefit limit" with which to update the Administrative Algorithm and Health Plan Guide, two documents Clinical Reviewers rely upon in evaluating prior authorization requests.

150. However, after these changes to the administrative algorithm and other job aids were implemented, on March 1, 2019, an announcement to reviewers stated that these updates to the Administrative Algorithm and Health Plan Guide were "minor updates to language that don't affect algorithm."

151. On March 13, 2019, eviCore and WellCare held a conference call to discuss their management of the WellCare Florida CMS Medicaid pediatric population. Among the attendees on the conference call were Vycki Rupakus, Cayce Awe, Chris Chapman, and Dan Moffett of eviCore; and Tanya Hillary, Alan Smith, and Claudius Conner of WellCare.

152. During this call, eviCore proposed four review processes as potential paths forward for WellCare's Florida Medicaid CMS population.

153. Option 1 was to continue the auto-approval scheme eviCore and WellCare had previously agreed upon. In discussing Option 1, Chris Chapman eviCore's Director of Account Management, acknowledged the need to "get away from the term 'auto approval,'" and noted the alternative language "approved at the direction of the healthplan." Chapman confirmed that the substance of the review under Option 1, however, would still be to "just approve the requested amount."

154. Option 3 was the only one of the proposed options that included the "medical necessity review" required by law. One "consideration" identified with regard to Option 3 was the "Cost to eviCore" that would be associated with a full medical necessity review.

155. On March 15, 2019, eviCore had an internal conference call to follow up on the issues raised with WellCare on March 13, and to decide upon a plan of action. During this call, Chapman discussed departing from the auto-approval scheme as a decision between staying "within the constraints of what we currently do versus implementing a whole new process that's going to require a lot of resources from eviCore."

156. On the same call, Cayce Awe, eviCore's Vice President for Strategic Client Relationships noted that eviCore makes a limited amount of money per year per patient with regard to the population at issue, and proposed that eviCore "look at each approach as to whether or not that keeps us within at least that spend, you know, our cost."

157. One method eviCore management discussed for minimizing review costs was further CorePath automation: "the intent would be that on the phone and on the web we would be able to automate 90 percent" of review.

158. eviCore management also discussed proposing to WellCare an "educate and pay" review system. "Educate and pay" does not involve full medical necessity review – instead, a

medically unnecessary provider request is approved, but eviCore also explains to the provider why the request did not meet medical necessity and sends the provider instructional criteria for future requests. As Daniel Moffett, eviCore's Vice President of MSK Operations, summarized, "'educate and pay' just overwrites it at the end and says 'this would have been the decision, however, because of blah blah blah, we're approving it. . . . [W]e're not even going to send it to review, we're just going to identify the member and send this criteria."

159. Ultimately, at the conclusion of the March 15 call, eviCore management settled on "educate and pay" as the best proposal to WellCare. As noted above, "educate and pay" does not substantively differ from eviCore's normal auto-approval schemes with regard to the rate at which requests are approved – its only difference is the provision of instructional criteria to providers.

E. eviCore's Fraudulent Scheme Caused the Submission of False Claims and Loss to the Federal and State Treasuries

160. Once a case has been approved by eviCore, the member received the outpatient or home health service at the facility, the facility submits the bill to the payor, and the payor pays for the service. In the case of government beneficiaries, the government programs ultimately pay for the service.

161. Accordingly, the vast majority of services that resulted from eviCore's scheme were approved for payment, performed, and reimbursed, despite the fact that none of the auto-approved cases had been properly qualified as medically reasonable and necessary, as is required for government reimbursement.

162. As a result of eviCore's scheme, government healthcare programs spent billions of dollars, paying for and/or reimbursing for services that were not medically reasonable or necessary.

163. By virtue of the false or fraudulent claims that Defendants knowingly caused to be presented, the United States and the Qui Tam States have suffered actual damages and are entitled to recover treble damages plus a civil monetary penalty for each false claim.

164. As a result of Defendants' fraudulent conduct, the government healthcare programs have been paying and continue to pay thousands of dollars daily for services which were and are not medically reasonable and necessary.

COUNT I
Violation of the Federal False Claims Act, 31 U.S.C. § 3729(a)(1)(A)
United States of America ex rel. Challenger LLC vs. eviCore and WellCare

165. Relator incorporates herein by reference each and every allegation of the preceding paragraphs of this Complaint as though fully set forth herein.

166. As a result of the foregoing conduct, eviCore and WellCare knowingly presented, or caused to be presented, false or fraudulent claims for payment, in violation of 31 U.S.C. § 3729(a)(1)(A).

167. The claims relevant to this Count include all claims for reimbursement of services ordered by treating providers for Medicare and Medicaid beneficiaries that were not medically reasonable or necessary, which were caused to be submitted by virtue of eviCore's and WellCare's scheme directly or indirectly, to Medicare and/or state Medicaid agencies.

168. eviCore caused the submission of such false claims through their client MCOs, including WellCare, knowing that those private entities were agents for the federal and/or state governments, that the auto-approved prior authorization requests would be submitted by the MCOs, including WellCare, to Medicare and/or state Medicaid agencies, and that for each and every auto-approved prior authorization request, the federal and/or state government would base its payments to MCOs, including WellCare, on those auto-approved prior authorization requests.

169. All such claims eviCore caused to be submitted were false because they were for services that were not properly qualified as medically reasonable or necessary.

170. eviCore had knowledge (as defined by the False Claims Act, 31 U.S.C. § 3729(b)(1)(A)) of the claims' falsity because, in its role as utilization review manager for its insurer clients it had actual and constructive knowledge of the medical information of the beneficiaries required to make the determination as to whether or not the services ordered were medically reasonable and necessary, and because, as utilization review manager for its insurer clients, eviCore was obligated by contract as well as under federal and state regulations to ensure such services so ordered were medically reasonable and necessary.

171. WellCare had knowledge (as defined by the False Claims Act, 31 U.S.C. § 3729(b)(1)(A)) of the claims' falsity because of its directions to eviCore to authorize claims without regard to whether such services were medically reasonable and necessary.

172. As a result of eviCore's and WellCare's actions as set forth above in this Complaint, the United States of America has been, and continues to be, severely damaged.

COUNT II
Violation of Federal False Claims Act, 31 U.S.C. § 3729(a)(1)(B)
United States of America ex rel. SW Challenger LLC vs. eviCore and WellCare

173. Relator incorporates herein by reference each and every allegation of the preceding paragraphs of this Complaint as though fully set forth herein.

174. As a result of the foregoing conduct, eviCore and WellCare knowingly made, used, or caused to be made or used, false or fraudulent records or statements material to the payment of false or fraudulent claims, in violation of 31 U.S.C. § 3729(a)(1)(B).

175. The claims relevant to this Count include all claims for reimbursement of services ordered by treating providers for Medicare and Medicaid beneficiaries that were not medically

reasonable or necessary, which were caused to be submitted by virtue of eviCore's scheme, directly or indirectly, to Medicare and/or state Medicaid agencies.

176. The false or fraudulent records or statements underlying the false claims relevant to this Count include all false or fraudulent records or statements regarding the medical reasonableness and necessity of services ordered by treating providers for Medicare and Medicaid beneficiaries made by eviCore to its client MCOs, including WellCare, in carrying out its scheme.

177. eviCore made false or fraudulent records or statements underlying the false claims to its client MCOs, including WellCare, knowing that the auto-approved prior authorizations had not been subject to a determination of medically reasonableness and necessity, that its client MCOs were private entities acting as agents for the federal and/or state governments, and that the auto-approved prior authorizations would be material to the payment decisions of these MCOs, who in turn, paid for all such resulting claims out of the federal and/or state funds.

178. All such resulting claims eviCore caused to be submitted were false because the prior authorization approvals that were the result of auto-approve, all-or-nothing, or CorePath AI schemes were for services that were not properly qualified as medically reasonable or necessary.

179. eviCore had knowledge (as defined by the False Claims Act, 31 U.S.C. § 3729(b)(1)(A)) of the claims' falsity because, in its role as utilization review manager for its insurer clients, it had actual and constructive knowledge of the medical information of the beneficiaries required to make the determination as to whether or not the services ordered were medically reasonable or necessary, and because as utilization review manager for its insurer clients, eviCore was obligated by contract as well as under federal and state regulations to ensure such services so ordered were medically reasonable and necessary.

180. WellCare had knowledge (as defined by the False Claims Act, 31 U.S.C. § 3729(b)(1)(A)) of the claims' falsity because of its directions to eviCore to authorize claims without regard to whether such services were medically reasonable and necessary.

181. The United States of America, unaware of the falsity of the records or statements underlying the false claims caused to be made by eviCore, and in reliance on the accuracy of these records or statements underlying the false claims, paid and may still be paying or reimbursing for services which were and are not medically reasonable and necessary.

COUNT III
Violation of Alaska Medical Assistance False Claims and Reporting Act
State of Alaska vs. eviCore

182. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein.

183. This is a civil action brought by Relator on behalf of the State of Alaska against Defendant eviCore, under the Alaska Medical Assistance False Claims and Reporting Act, Alaska Stat. § 09.58.010 et seq.

184. The State of Alaska and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Alaska.

185. One or more MCOs, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services.

186. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, to

officers or employees of the State of Alaska or one of its agencies false or fraudulent claims for payment or approval, in violation of Alaska Stat. § 09.58.010 et seq.

187. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used, or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements to secure the payment or approval by the State of Alaska, or its political subdivisions, false records or statements material to false or fraudulent claims, in violation of Alaska Stat. § 09.58.010 et seq.

188. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, and with actual knowledge of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements to conceal, avoid, or decrease an obligation to pay or transmit money to the State of Alaska, or its political subdivisions, in violation of Alaska Stat. § 09.58.010 et seq.

189. The State of Alaska and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

190. As a result of Defendants' actions, as set forth above, the State of Alaska and/or its agencies or political subdivisions have been, and may continue to be, severely damaged

COUNT IV
Violation of Connecticut False Claims Act
State of Connecticut vs. eviCore

191. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein.

192. This is a civil action brought by Relator on behalf of the State of Connecticut against Defendant eviCore, under the State of Connecticut's False Claims Act for Medical Assistance Programs, Conn. Gen. Stat. § 4-277.

193. The State of Connecticut and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Connecticut.

194. One or more MCOs, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services.

195. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, to officers or employees of the State of Connecticut or one of its agencies false or fraudulent claims for payment or approval under a medical assistance program administered by the Department of Social Services, in violation of Conn. Gen. Stat. § 4-275(a)(1).

196. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used, or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements to secure the payment or approval by the State of Connecticut, or its political subdivisions, false or fraudulent claims under a medical assistance program administered by the Department of Social Services, in violation of Conn. Gen. Stat. § 4-275(a)(2).

197. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, and with actual knowledge of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements to conceal, avoid, or decrease an obligation to pay or transmit money to the State of Connecticut, or its political subdivisions, under a medical assistance program administered by the Department of Social Services, in violation of Conn. Gen. Stat. § 4-275(a)(7).

198. The State of Connecticut and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

199. As a result of Defendants' actions, as set forth above, the State of Connecticut and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT V
Violation of Florida False Claims Act
State of Florida vs. eviCore and WellCare

200. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein.

201. This is a civil action brought by Relator on behalf of the State of Florida against Defendant eviCore, under the State of Florida's False Claims Act, FLA. STAT. ANN. § 68.083(2).

202. The State of Florida and/or one of its agents contracted, directly or indirectly, with Wellcare in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Florida.

203. WellCare, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services.

204. Defendants eviCore and WellCare, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, to officers or employees of the State of Florida or one of its agencies false or fraudulent claims for payment or approval, in violation of FLA. STAT. ANN. § 68.082(2)(a).

205. Defendants eviCore and WellCare, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used, or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements to get false or fraudulent claims paid or approved by the State of Florida or one of its agencies, in violation of FLA. STAT. ANN. § 68.082(2)(b).

206. Defendants eviCore and WellCare, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements to conceal, avoid, or decrease an obligation to pay or transmit money to the State of Florida or one of its agencies, in violation of FLA. STAT. ANN. § 68.082 (2)(g).

207. The State of Florida and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendants eviCore and WellCare, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that

are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

208. As a result of Defendants' actions, as set forth above, the State of Florida and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT VI
Violation of Illinois False Claims Act
State of Illinois vs. eviCore

209. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein.

210. This is a civil action brought by Relator on behalf of the State of Illinois against Defendant eviCore, under the Illinois False Claims Act, 740 ILL. COMP. STAT. ANN. 175/4(b).

211. The State of Illinois and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Illinois.

212. MCOs, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services.

213. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented, or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval, in violation of 740 ILL. COMP. STAT. ANN. 175/3(a)(1)(A).

214. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used, or caused to be made or used, and may still be making, using, or causing

to be made or used, false records or statements material to false or fraudulent claims, in violation of 740 ILL. COMP. STAT. ANN. 175/3(a)(1)(B).

215. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used, or caused to be made or used, and may still be making, using, or causing to be made or used, false records or statements material to obligations to pay or transmit money or property to the state or knowingly concealed or knowingly and improperly avoided or decreased or may still be knowingly concealing or knowingly and improperly avoiding or decreasing obligations to pay or transmit money or property to the state, in violation of 740 ILL. COMP. STAT. ANN. 175/3(a)(1)(G).

216. The State of Illinois and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of those claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

217. As a result of Defendants' actions, as set forth above, the State of Illinois and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT VII
Violation of the Michigan Medicaid False Claims Act
State of Michigan vs. eviCore

218. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein.

219. This is a civil action brought by Relator in the name of the State of Michigan against Defendant eviCore, under the Michigan Medicaid False Claims Act, MICH. COMP. LAWS ANN. § 400.610a(l).

220. The State of Michigan and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Michigan.

221. MCOs, including WellCare, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services.

222. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made or caused to be made, and may still be making or causing to be made, false statements or false representations of material facts in applications for Medicaid benefits, in violation of MICH. COMP. LAWS ANN. § 400.603(1).

223. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made or cause to be made false statements or false representations of material facts for use in determining rights to Medicaid benefits, in violation of MICH. COMP. LAWS ANN. § 400.603(2).

224. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly concealed or failed to disclose, and may still be concealing or failing to disclose, events affecting their initial or continued rights to receive Medicaid benefits or the initial or continued rights of any other person on whose behalf Defendant has applied for or are receiving benefits for,

with intent to obtain benefits to which Defendant or other persons are not entitled or in an amount greater than that to which Defendant or other persons are entitled, in violation of MICH. COMP. LAWS ANN. § 400.603(3).

225. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made or presented or caused to be made or presented, and may still be making or presenting or causing to be made or presented to employees or officers of the State of Michigan, false claims under the social welfare act, Act No. 280 of the Public Acts of 1939, in violation of MICH. COMP. LAWS ANN. § 400.607(1).

226. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made or presented or caused to be made or presented, and may still be making or presenting or causing to be made or presented claims under the social welfare act, Act No. 280 of the Public Acts of 1939, that falsely represent that the goods or services for which the claims were made were medically necessary in accordance with professionally accepted standards, in violation of MICH. COMP. LAWS ANN. § 400.607(2).

227. The State of Michigan, and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

228. As a result of Defendant eviCore's actions, as set forth above, the State of Michigan and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT VIII
Violation of New Jersey False Claims Act
State of New Jersey vs. eviCore

229. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein.

230. This is a civil action brought by Relator, in the name of the State of New Jersey, against Defendant eviCore, pursuant to the State of New Jersey False Claims Act, N.J. STAT. ANN. § 2A:32C-5(b).

231. The State of New Jersey and/or one of its agents contracted, directly or indirectly, with one or more carrier contractors in connection with the administration of Medicaid claims and/or claims under other state-funded plans in New Jersey.

232. MCOs, including WellCare, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services.

233. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be causing to be presented, to an employee, officer or agent of the State, or to any contractor, grantee, or other recipient of State funds, false or fraudulent claims for payment or approval under the New Jersey Medicaid program, in violation of N.J. STAT. ANN. § 2A:32C-3(a).

234. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using, or causing to be made or used, false records or statements to get false or fraudulent claims paid or approved by the State, in violation of N.J. STAT. ANN. § 2A:32C-3(b).

235. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using, or causing to be made or used, false records or statements to conceal, avoid or decrease obligations to pay or transmit money or property to the State, in violation of N.J. STAT. ANN. § 2A:32C-3(g).

236. The State of New Jersey and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

237. As a result of Defendants' actions, as set forth above, the State of New Jersey and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT IX
Violation of New York False Claims Act
State of New York vs. eviCore

238. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein.

239. This is a civil action brought by Relator on behalf of the State of New York against Defendant eviCore, under the State of New York False Claims Act, N.Y. STATE FIN. LAW § 190(2).

240. The State of New York and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in New York.

241. MCOs, including WellCare, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services.

242. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval, in violation of N.Y. STATE FIN. LAW § 189(1)(a).

243. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims, in violation of N.Y. STATE FIN. LAW § 189(1)(b).

244. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used, or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to obligations to pay or transmit money or property to the State of New York or one of its political subdivisions, in violation of N.Y. STATE FIN. LAW § 189(1)(g).

245. The State of New York, and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable or necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

246. As a result of Defendants' actions, as set forth above, the State of New York and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT X
Violation of Louisiana Medical Assistance Programs Integrity Law
State of Louisiana vs. eviCore

247. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein. The allegations contained in this Count are based upon information and belief.

248. This is a civil action brought by Relator in the name of the State of Louisiana against Defendant eviCore, under the Louisiana Medical Assistance Programs Integrity Law, LA. REV. STAT. ANN. § 46:439.1(A).

249. The State of Louisiana and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Louisiana.

250. MCOs, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services for Louisiana state-funded plan beneficiaries.

251. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval under the Medicaid program, in violation of LA. REV. STAT. ANN. § 46:438.3(A).

252. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims to get such false

or fraudulent claims under the Medicaid program, in violation of LA. REV. STAT. ANN. § 46:438.3(B).

253. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to obligations to pay or transmit money or property to the state, or knowingly concealing or knowingly and improperly avoiding or decreasing obligations to pay or transmit money or property to the state, relative to the Medicaid program, in violation of LA. REV. STAT. ANN. § 46:438.3(C).

254. The State of Louisiana, and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

255. As a result of Defendants' actions, as set forth above, the State of Louisiana and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT XI
Violation of Montana False Claims Act
State of Montana vs. eviCore

256. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein. The allegations contained in this Count are based upon information and belief.

257. This is a civil action brought by Relator in the name of the State of Montana against Defendant eviCore, under the Montana False Claims Act, MONT. CODE ANN. § 17-8-406.

258. The State of Montana and/or one of its agents contracted, directly or indirectly, with one or more MCOs, including WellCare, in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Montana.

259. MCOs, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services for Montana state-funded plan beneficiaries.

260. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval under the Medicaid program and/or other state-funded programs, in violation of MONT. CODE ANN. § 17-8-403(1)(a).

261. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims to get such false or fraudulent claims under the Medicaid program and/or other state-funded programs paid for or approved, in violation of MONT. CODE ANN. § 17-8-403(1)(b).

262. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to obligations to pay or transmit money or property to the state, or knowingly concealing or knowingly and improperly avoiding or decreasing

obligations to pay or transmit money or property to the state, relative to the Medicaid program and/or other state-funded programs, in violation of MONT. CODE ANN. § 17-8-403(1)(g).

263. The State of Montana, and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

264. As a result of Defendants' actions, as set forth above, the State of Montana and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT XII
Violation of New Mexico Medicaid False Claims Act
State of New Mexico vs. eviCore

265. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein. The allegations contained in this Count are based upon information and belief.

266. This is a civil action brought by Relator in the name of the State of New Mexico against Defendant eviCore, under the New Mexico Medicaid False Claims Act, N.M. STAT. ANN. § 27-14-7(B).

267. The State of New Mexico and/or one of its agents contracted, directly or indirectly, with one or more MCOs, including WellCare, in connection with the administration of Medicaid claims and/or claims under other state-funded plans in New Mexico.

268. MCOs, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services for New Mexico state-funded plan beneficiaries.

269. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval under the Medicaid program and/or other state-funded programs, in violation of N.M. STAT. ANN. § 27-14-4(A).

270. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims to get such false or fraudulent claims under the Medicaid program and/or other state-funded programs paid for or approved, in violation of N.M. STAT. ANN. § 27-14-4(B).

271. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to obligations to pay or transmit money or property to the state, or knowingly concealing or knowingly and improperly avoiding or decreasing obligations to pay or transmit money or property to the state, relative to the Medicaid program and/or other state-funded programs, in violation of N.M. STAT. ANN. § 27-14-4(E).

272. The State of New Mexico, and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

273. As a result of Defendants' actions, as set forth above, the State of New Mexico and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT XIII
Violation of North Carolina False Claims Act
State of North Carolina vs. eviCore

274. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein.

275. This is a civil action brought by Relator on behalf of the State of North Carolina against Defendant eviCore, under the State of North Carolina's False Claims Act, N.C. GEN. STAT. § 1-608(b).

276. The State of North Carolina and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in North Carolina.

277. One or more MCOs, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services.

278. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval under the Medicaid program and/or other state-funded programs, in violation of N.C. GEN. STAT. § 1-607(a)(1).

279. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims to get such false or fraudulent

claims under the Medicaid program and/or other state-funded programs paid for or approved, in violation of N.C. GEN. STAT. § 1-607(a)(2).

280. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to obligations to pay or transmit money or property to the state, or knowingly concealing or knowingly and improperly avoiding or decreasing obligations to pay or transmit money or property to the state, relative to the Medicaid program and/or other state-funded programs, in violation of N.C. GEN. STAT. § 1-607(a)(7).

281. The State of North Carolina and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

282. As a result of Defendants' actions, as set forth above, the State of North Carolina and/or its agencies or political subdivisions have been, and may continue to be, severely damaged

COUNT XIV
Violation of Oklahoma Medicaid False Claims Act
State of Oklahoma vs. eviCore

283. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein. The allegations contained in this Count are based upon information and belief.

284. This is a civil action brought by Relator in the name of the State of Oklahoma against Defendant eviCore, under the Oklahoma Medicaid False Claims Act, OKLA. STAT. ANN. tit. 63, § 5053.2.B.1.

285. The State of Oklahoma and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Oklahoma.

286. MCOs, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services for Oklahoma state-funded plan beneficiaries.

287. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval under the Medicaid program and/or other state-funded programs, in violation of OKLA. STAT. ANN. tit. 63, § 5053.1.B.1.

288. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims to get such false or fraudulent claims under the Medicaid program and/or other state-funded programs paid for or approved, in violation of OKLA. STAT. ANN. tit. 63, § 5053.1.B.2.

289. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to

be made or used, false records or statements material to obligations to pay or transmit money or property to the state, or knowingly concealing or knowingly and improperly avoiding or decreasing obligations to pay or transmit money or property to the state, relative to the Medicaid program and/or other state-funded programs, in violation of OKLA. STAT. ANN. tit. 63, § 5053.1.B.7.

290. The State of Oklahoma, and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

291. As a result of Defendants' actions, as set forth above, the State of Oklahoma and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT XV
Violation of Tennessee False Claims Act
State of Tennessee vs. eviCore

292. Relator incorporates herein by reference the preceding paragraphs of this Complaint as though fully set forth herein.

293. This is a civil action brought by Relator, on behalf of the State of Tennessee, against Defendants under Tennessee's False Claims Act, Tenn. Code Ann. §71-5-181, et seq.

294. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval under the Medicaid program, in violation of TENN. CODE ANN. § 71-5-182(a)(1)(A).

295. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims to get such false or fraudulent claims under the Medicaid program paid for or approved, in violation of TENN. CODE ANN. § 71-5-182(a)(l)(B).

296. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used, or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to obligations to pay or transmit money or property to the state, or knowingly concealing or knowingly and improperly avoiding or decreasing obligations to pay or transmit money or property to the state, relative to the Medicaid program, in violation of TENN. CODE ANN. § 71-5-182(a)(1)(D).

297. The State of Tennessee, or its political subdivisions, unaware of the falsity of the claims and/or statements made, or knowingly caused to be made, by eviCore, and in reliance upon the accuracy of these claims and/or statements, paid, and may continue to pay, for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

298. As a result of Defendants' actions, as set forth above, the State of Tennessee and/or its political subdivisions have been, and may continue to be, severely damaged.

COUNT XVI
Violation of Texas Medicaid Fraud Prevention Act
State of Texas vs. eviCore

299. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein. The allegations contained in this Count are based upon information and belief.

300. This is a civil action brought by Relator in the name of the State of Texas against Defendant eviCore, under the Texas Medicaid Fraud Prevention Act, TEX. HUM. RES. CODE ANN. § 36.101.

301. The State of Texas and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Texas.

302. MCOs, including HCSC, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services for Texas state-funded plan beneficiaries.

303. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval under the Medicaid program and/or other state-funded programs, in violation of TEX. HUM. RES. CODE ANN. § 36.002(1).

304. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims to get such false

or fraudulent claims under the Medicaid program and/or other state-funded programs paid for or approved, in violation of TEX. HUM. RES. CODE ANN. § 36.002(2).

305. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to obligations to pay or transmit money or property to the state, or knowingly concealing or knowingly and improperly avoiding or decreasing obligations to pay or transmit money or property to the state, relative to the Medicaid program and/or other state-funded programs, in violation of TEX. HUM. RES. CODE ANN. § 36.002(12).

306. The State of Texas, and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

307. As a result of Defendants' actions, as set forth above, the State of Texas and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT XVII
Violation of Washington Medicaid Fraud False Claims Act
State of Washington vs. eviCore

308. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein. The allegations contained in this Count are based upon information and belief.

309. This is a civil action brought by Relator in the name of the State of Washington against Defendant eviCore, under the Washington Medicaid Fraud False Claims Act, WASH. REV. CODE § 74.66.050.

310. The State of Washington and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Washington.

311. MCOs, including WellCare, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services for Washington state-funded plan beneficiaries.

312. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval under the Medicaid program and/or other state-funded programs, in violation of WASH. REV. CODE § 74.66.020(1)(a).

313. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims to get such false or fraudulent claims under the Medicaid program and/or other state-funded programs paid for or approved, in violation of WASH. REV. CODE § 74.66.020(1)(b).

314. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to

be made or used, false records or statements material to obligations to pay or transmit money or property to the state, or knowingly concealing or knowingly and improperly avoiding or decreasing obligations to pay or transmit money or property to the state, relative to the Medicaid program and/or other state-funded programs, in violation of WASH. REV. CODE § 74.66.020(1)(g).

315. The State of Washington, and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

316. As a result of Defendants' actions, as set forth above, the State of Washington and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

PRAYER FOR RELIEF

WHEREFORE, Relators pray that judgment be entered against Defendant, ordering as follows:

A. That Defendant cease and desist from violating 31 U.S.C. § 3729, *et seq.*; ALASKA STAT. § 09.58.010, *et seq.*; CONN. GEN. STAT. § 4-277, *et seq.*; FLA. STAT. ANN. § 68.081, *et seq.*; 740 ILL. COMP. STAT. ANN. 175/1, *et seq.*; LA. REV. STAT. ANN. § 46:437.1, *et seq.*; MICH. COMP. LAWS ANN. § 400.601, *et seq.*; MONT. CODE ANN. § 17-8-401, *et seq.*; N.C. GEN. STAT. § 1-605, *et seq.*; N.J. STAT. ANN. § 2A:32C-1, *et seq.*; N.M. STAT. ANN. § 27-14-1, *et seq.*; N.Y. STATE FIN. LAW § 187, *et seq.*; OKLA. STAT. ANN. tit. 63, § 5053, *et seq.*; TENN. CODE ANN. §71-5-182, *et seq.*; TEX. HUM. RES. CODE ANN. § 36.001, *et seq.*; and WASH. REV. CODE § 74.66.005, *et seq.*;

B. That civil penalties of not less than $11,181 or more than $22,363 per claim as provided by 31 U.S.C. § 3729(a) and adjusted for inflation be imposed for each and every false or fraudulent claim that Defendant caused to be submitted to the United States and/or its grantees, for each false record or statement Defendant made, used, or caused to be made or used that was material to a false or fraudulent claim, that three times the amount of damages the United States sustained because of Defendants' actions also be imposed;

C. That judgment be entered in Relator's favor and against Defendants in the amount of the damages sustained by the State of Alaska or its political subdivisions multiplied as provided for in Alaska Stat. § 09.58.010 et seq., plus a civil penalty of not less than $5,500 or more than $11,000 as provided by Alaska Stat. § 09.58.010 et seq., and adjusted for inflation, to the extent such multiplied penalties shall fairly compensate the State of Alaska or its political subdivisions for losses resulting from the various schemes undertaken by Defendants, together with penalties

for specific claims to be identified at trial after full discovery and attorney fees and costs as provided by Alaska Stat. § 09.58.010(c).

D. That judgment be entered in Relators' favor and against Defendants in the amount of the damages sustained by the State of Connecticut multiplied as provided for in Conn. Gen. Stat. § 4-275(b)(2), plus a civil penalty of not less than $11,181 or more than $22,363 for each act in violation of the State of Connecticut False Claims Act, as provided by Conn. Gen. Stat. § 4-275(b)(1) and adjusted for inflation, to the extent such multiplied penalties shall fairly compensate the State of Connecticut for losses resulting from the various schemes undertaken by Defendants, together with penalties for specific claims to be identified at trial after full discovery.

E. That judgment be entered in Relators' favor and against Defendants in the amount of the damages sustained by the State of Florida or its agencies or political subdivisions, multiplied as provided for in FLA. STAT. ANN. § 68.082(2), plus a civil penalty of not less than five thousand five hundred dollars ($5,500) or more than eleven thousand dollars ($11,000), as provided by FLA. STAT. ANN. § 68.082, to the extent such penalties shall fairly compensate the State of Florida or its agencies or political subdivisions for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

F. That judgment be entered in Relators' favor and against Defendant in the amount of the damages sustained by the State of Illinois or its agencies or political subdivisions, multiplied as provided for in 740 ILL. COMP. STAT. ANN. 175/3(a)(1), plus a civil penalty of not less than $11,181 or more than $22,363, as provided for in 740 ILL. COMP. STAT. ANN. 175/3(a)(1) and adjusted for inflation, and the costs of this civil action as provided by 740 ILL. COMP. STAT. ANN. 175/3(a)(2), to the extent such penalties shall fairly compensate the State of Illinois or its

agencies or political subdivisions for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

G. That judgment be entered in Relators' favor and against Defendant in the amount of the damages sustained by the State of Louisiana or its agencies or political subdivisions, plus a fine of not to exceed ten thousand dollars ($10,000) or three times the value of the illegal remuneration, whichever is greater, as provided for in LA. REV. STAT. ANN. § 46:438.6, plus a civil penalty of not less than five thousand five hundred dollars ($5,500) or more than eleven thousand dollars ($11,000) for each act in violation of the Louisiana Medical Assistance Programs Integrity Law, to the extent such penalties shall fairly compensate the State of Louisiana for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

H. That judgment be entered in Relators' favor and against Defendant in the amount of damages sustained by the State of Michigan or its agencies or political subdivisions, for the value of payments or benefits provided, directly or indirectly, as a result of Defendants' unlawful acts, as provided for in MICH. COMP. LAWS ANN. §§ 400.603 – 400.606, 400.610b, in order to fairly compensate the State of Michigan or its agencies or political subdivisions for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

I. That judgment be entered in Relators' favor and against Defendants in the amount of the damages sustained by the State of Montana or its agencies or political subdivisions, multiplied times three, as provided for in MONT. CODE ANN. § 17-8-403, plus a civil penalty of not less than five thousand five hundred dollars ($5,500) or more than eleven thousand dollars ($11,000) for each act in violation of the Montana False Claims Act, and the attorney fees,

expenses, and costs of this civil action as provided by MONT. CODE ANN. § 17-8-403, to the extent such penalties shall fairly compensate the State of Montana for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

J. That judgment be entered in Relators' favor and against Defendants in the amount of the damages sustained by the State of New Jersey or its agencies or political subdivisions, multiplied as provided for in N.J. STAT. ANN. § 2A:32C-3, plus a civil penalty of not less than $11,181 or more than $22,363 as allowed under the federal False Claims Act (31 U.S.C. § 3729 et seq.) for each act in violation, to the extent such penalties shall fairly compensate the State of New Jersey or its agencies or political subdivisions for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

K. That judgment be entered in Relators' favor and against Defendants in the amount of the damages sustained by the State of New Mexico or its agencies or political subdivisions, multiplied times three, as provided for in N.M. STAT. ANN. §§ 27-14-2, 27-14-4, plus a civil penalty of not less than $5,000 and not more than $10,000 for each claim as provided by N.M. STAT. ANN. 44-9-3 , and attorney fees and costs of this civil action as provided by N.M. STAT. ANN. 44-9-1 *et seq*. and N.M. STAT. ANN. 27-14-1 *et seq*., to the extent such penalties shall fairly compensate the State of New Mexico for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

L. That judgment be entered in Relators' favor and against Defendants in the amount of damages sustained by the State of New York or its agencies or political subdivisions, multiplied as provided for in N.Y. STATE FIN. LAW § 189(1)(h), plus a civil penalty of not less than six

thousand dollars ($6,000) or more than twelve thousand dollars ($12,000) for each false claim, pursuant to N.Y. STATE FIN. LAW § 189(1)(h), to the extent such penalties shall fairly compensate the State of New York or its agencies or political subdivisions for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

M. That judgment be entered in Relator's favor and against Defendants in the amount of the damages sustained by the State of North Carolina, multiplied as provided for in N.C. Gen. Stat. § 1-605 et seq., plus a civil penalty of not less than $5,500 and not more than $11,000 for each violation as provided by N.C. Gen. Stat. § 1-607, and the costs of this civil action as provided by N.C. Gen. Stat. § 1-607, to the extent such penalties shall fairly compensate the State of North Carolina for losses resulting from the various schemes undertaken by Defendants, together with penalties for specific claims to be identified at trial after full discovery.

N. That judgment be entered in Relators' favor and against Defendants in the amount of the damages sustained by the State of Oklahoma or its agencies or political subdivisions, multiplied times three, as provided for in OKLA. STAT. ANN. tit. 63, § 5053.1, plus a civil penalty of not less than $11,181 or more than $22,363 as provided by OKLA. STAT. ANN. tit. 63, § 5053.1(B) and adjusted for inflation, to the extent such penalties shall fairly compensate the State of Oklahoma for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

O. That judgment be entered in Relator's favor and against Defendants in the amount of the damages sustained by the State of Tennessee, multiplied as provided for in Tenn. Code Ann. § 71-5-181, et seq., plus a civil penalty of not less than $5,000 and not more than $25,000 and adjusted for inflation as provided by Tenn. Code Ann. § 71-5-182, and the costs of this civil action

as provided by Tenn. Code Ann. § 71-5-182, to the extent such penalties shall fairly compensate the State of Tennessee for losses resulting from the various schemes undertaken by Defendants, together with penalties for specific claims to be identified at trial after full discovery.

P. That judgment be entered in Relators' favor and against Defendants in the amount of the damages sustained by the State of Texas or its agencies or political subdivisions, multiplied times two, as provided for in TEX. HUM. RES. CODE ANN. § 36.052, plus a civil penalty of not less than $11,181 or more than $22,363, pursuant to TEX. HUM. RES. CODE ANN. § 36.052(a)(3) and adjusted for inflation, to the extent such penalties shall fairly compensate the State of Texas for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

Q. That judgment be entered in Relators' favor and against Defendants in the amount of the damages sustained by the State of Washington or its agencies or political subdivisions, multiplied times three, as provided for in WASH. REV. CODE § 74.66.020, plus a civil penalty of not less than the greater of $10,957 or the minimum inflation adjusted penalty amount imposed as provided by 31 U.S.C. § 3729(a) and not more than the greater of $21,916 or the maximum inflation adjusted penalty amount imposed as provided by 31 U.S.C. § 3729(a) for each act in violation of the Washington Medicaid Fraud False Claims Act, to the extent such penalties shall fairly compensate the State of Washington for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery; and

R. That Defendants be enjoined from concealing, removing, encumbering, or disposing of assets which may be required to pay the civil monetary penalties imposed by the Court;

S. That Defendants disgorge all sums by which they have been enriched unjustly by their wrongful conduct;

T. That Relators be awarded the maximum amount allowed pursuant to 31 U.S.C. § 3730(d) and § 3730(h), ALASKA STAT. § 09.58.010, *et seq.*; CONN. GEN. STAT. § 4-277, *et seq.*, FLA. STAT. ANN. § 68.081, *et seq.*, 740 ILL. COMP. STAT. ANN. 175/1, *et seq.*, LA. REV. STAT. ANN. § 46:437.1, *et seq.*, MICH. COMP. LAWS ANN. § 400.601, *et seq*; MONT. CODE ANN. § 17-8-401, *et seq.*; N.C. GEN. STAT. § 1-605, *et seq.*; N.J. STAT. ANN. § 2A:32C-1, *et seq.*, N.M. STAT. ANN. § 27-14-1, *et seq.*, N.Y. STATE FIN. LAW § 187, *et seq.*, OKLA. STAT. ANN. tit. 63, § 5053, *et seq.*; TENN. CODE ANN. §71-5-182, *et seq.*; TEX. HUM. RES. CODE ANN. § 36.001, *et seq*; and WASH. REV. CODE § 74.66.005, *et seq.*;

U. That Relators be awarded all costs, including but not limited to, court costs, expert fees and all attorney fees, costs and expenses incurred by Relators in the prosecution of this suit; and

V. That Relators be granted such other and further relief as the Court deems just and proper.

JURY TRIAL DEMAND

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, SW Challenger demands a trial by jury of all issues so triable.

DATED: March 20, 2019

Respectfully submitted,

SEEGER WEISS LLP

By: _____

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Counsel for Plaintiff SW Challenger, LLC

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA

ex rel. [UNDER SEAL],

Plaintiffs,

vs.

[UNDER SEAL],

Defendant.

Case No. 19-2501

JURY TRIAL DEMANDED

FIRST AMENDED COMPLAINT FOR VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT, 31 U.S.C. § 3729, *ET SEQ.*

UNDER SEAL
Pursuant to 31 U.S.C. § 3730(b)(2)

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

x

UNITED STATES OF AMERICA

ex rel. SW CHALLENGER, LLC,

Plaintiffs,

vs.

EVICORE HEALTHCARE MSI, LLC,

Defendant.

x

Case No. 19-2501

JURY TRIAL DEMANDED

FIRST AMENDED COMPLAINT FOR VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT, 31 U.S.C. § 3729, *ET SEQ.*

UNDER SEAL
Pursuant to 31 U.S.C. § 3730(b)(2)

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Plaintiff, SW Challenger, LLC ("SW Challenger"), on behalf of the United States of America (the "United States"), brings this action pursuant to the Qui Tam provisions of the Federal Civil False Claims Act, 31 U.S.C. §§ 3729, *et seq.*, as amended (the "False Claims Act"), against eviCore Healthcare MSI, LLC ("eviCore"). In support thereof, SW Challenger alleges as follows:

I. SUMMARY OF FACTUAL ALLEGATIONS

1. This is an action to recover damages and civil penalties on behalf of the United States arising from false and/or fraudulent records, statements and claims made, used or presented and/or caused to be made, used or presented by Defendant and/or its agents or employees under the Federal False Claims Act.

2. Under the Medicare Part C Program, known as Medicare Advantage, the federal agency that administers the Medicare program — the Centers for Medicare and Medicaid Services ("CMS") — contracts with private health-insurance companies (known as managed care organizations ("MCOs")), such as WellCare Health Plans, Inc. ("WellCare"), Passport, Blue Cross Blue Shield ("BCBS"), the Health Care Service Corporation ("HCSC"), Health Alliance Medical Plan ("HAMP"), and Moda Health, that operate health-insurance plans (known as "Medicare Advantage Plans") that cover Medicare beneficiaries. In sum, Medicare Advantage Plans are a type of Medicare health plan offered by a private company that contracts with Medicare to provide all of a beneficiary's Part A (Hospital Insurance) and Part B (Medical Insurance) benefits.

3. In administering government-funded Medicare Advantage Plans, MCOs are required to perform certain functions as set forth in their contractual agreements with CMS, including those related to prior authorization and utilization management and payment processing for outpatient and home health services.

4. CMS pays MCOs a capitated (per enrollee) amount to provide all Part A and B benefits. In addition, CMS makes a separate payment to MCOs for providing prescription drug benefits under Medicare Part D. Payments to MCOs are adjusted for enrollees' health status and other factors.

5. MCOs then share those payments with their sub-contractors and contracted medical providers.

6. CMS may terminate an MCO's Medicare Advantage contract for, among other things, the MCO carrying out its contract with CMS in a manner that is inconsistent with the effective and efficient implementation of the Medicare Advantage program, and if the MCO commits or participates in fraudulent or abusive activities affecting the Medicare program including the submission of fraudulent data. 42 CFR § 422.504(h)(1); 42 CFR § 422.510(a)(4)(i).

7. All contracts between CMS and MCOs specify that any subcontractor who is delegated part of the MCO's functions must comply with all applicable Medicare laws, regulations, and CMS instructions. 42 CFR § 422.504(i)(4)(v).

8. CMS further requires that MCO executives certify that the patient data that they submit to CMS is true and accurate. CMS requires these signed certifications as a condition of payment. If a subcontractor generates the data, the subcontractor also must certify that its patient data is true and accurate. 42 CFR § 422.504(l)(3).

9. Defendant eviCore is purportedly in the business of providing utilization management services for Medicare Advantage Plans for outpatient and home health services. Defendant eviCore contracts with MCOs to provide utilization management services and review prior authorization requests.

10. Utilization management is a core MCO function in the administration of Medicare Advantage plans, making eviCore subject to Medicare Advantage requirements as articulated in Medicare Advantage regulations and related guidance. *See, e.g.*, Medicare Managed Care Manual Chapter 11 - Medicare Advantage Application Procedures and Contract Requirements 100.5 – Administrative Contracting Requirements, *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c11.pdf ("CMS . . . view[s] contracts for. . . utilization management . . . to be administrative contracts subject to MA requirements as articulated in the MA regulation and related guidance."). As such, eviCore has agreed to comply with all applicable Medicare laws, regulations, and CMS instructions. *Id.*

11. One of the primary reasons that MCOs contract with third-parties like eviCore to perform these Government-mandated functions is to ensure that the MCO has in place procedures and systems to determine whether a particular medical procedure is reimbursable under Medicare Advantage. *See* 42 U.S.C. § 1395y(a)(1) ("Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B for any expenses incurred for items or services . . . which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member").

12. The entire purpose of this contractual arrangement, whereby eviCore provides sub-contracted medical review services to MCOs for the benefit of CMS, is to ensure that appropriate review procedures are in place and actually followed so as to reduce waste, fraud, and abuse within Medicare Advantage, and thus to ensure that medical procedures which are not reimbursable are denied.

13. Defendant eviCore knowingly accepted subcontracts from MCOs to take on the responsibility of providing CMS with prior authorization and utilization management for outpatient and home health services provided pursuant to Medicare Advantage. As such, eviCore was required to turn the same square corners in their dealings with MCOs as if they were dealing with the Government itself.

14. If eviCore agreed to contracts with MCOs to provide certain Government-mandated services, then eviCore's intentional failure to provide such services, or eviCore's use of a recklessly designed system that did not provide these services as called for by the MCOs' contracts with the Government, subjected eviCore to liability under the False Claims Act.

15. If eviCore failed to provide utilization management services and/or review prior authorization requests as contracted-for, and as a result an MCO approved treatments that were not reimbursable, that could result in patient harm and cost the Government a significant amount of taxpayer money.

16. Essentially, by entering into these agreements to provide services to MCOs, eviCore agreed to fulfill the role the MCO had in ensuring medically necessary treatments were approved and non-medically necessary treatments were denied under Medicare Advantage.

17. As relevant here, eviCore's contracts with MCOs include a key timing provision that requires eviCore to approve, partially approve, or deny in a timely fashion each request for prior authorization to deem services to a given beneficiary as reimbursable (each request also referred to as a "case"). In many instances, the turnaround time ("TAT") to process requests for prior authorizations is only 24 to 48 hours. Failure to meet its prescribed TAT will result in contractual penalties for eviCore.

18. Defendant eviCore, however, failed to hire sufficient staff to properly service its MCO subcontracts and meet the contractual timing requirements.

19. Rather, since at least November 2016, eviCore has engaged in fraudulent activities involving its role as the gatekeeper for determining whether requested services are appropriate and reimbursable. As detailed herein, through independent efforts to keep up with the high volume of prior authorization requests for services and to avoid contractual TAT penalties, eviCore instituted a scheme simply to "auto-approve" hundreds of cases on a daily basis, reflexively deeming those services as reasonable and necessary, even though there had been no appropriate evaluation of those cases, and in some cases, no actual human evaluation of those cases whatsoever.

20. Thus, to make up for its insufficient staffing, eviCore adopted procedures to automatically approve requested medical procedures without any meaningful clinical review or any limit on the scope of the procedure or the number of procedures approved. In layman's terms, for certain cases eviCore created a swinging gate prior authorization approval process that approved anything and everything that passed before it. In these circumstances, eviCore provided worthless services in exchange for its contractual payment to fulfill a necessary Government function that had been outsourced to MCOs and further subcontracted to eviCore.

21. Defendant eviCore specifically directed its medical personnel, internally called "Clinical Reviewers," including Relators, to "auto-approve" or "approve as requested" services in specific jurisdictions, for specific populations, and/or under specific healthcare plans, before and without any review of the propriety of the services.

22. These auto-approve directives, as described by eviCore to its reviewers, included, at various times, directives to Clinical Reviewers to "auto-approve" certain categories of services without any review.

23. Relators have direct personal knowledge of eviCore's conduct as it relates to the auto-approval of physical therapy treatment, but through their interactions with other reviewers working at eviCore, they learned that these procedures were not limited to physical therapy. Rather, upon information and belief, eviCore's auto-approval rubber-stamp had a large scope, including but not limited to the auto-approval of certain ***radiology services, cardiology procedures, interventional pain procedures, sleep therapy and laboratory management***. The risk of patient harm for services and procedures that are not medically necessary in these contexts could be significant.

24. In addition to the directives eviCore provided to its Clinical Reviewers, eviCore took further steps to ensure the approval of certain categories of requests by designing and implementing a data analytics system called "CorePath" that automatically approved certain requests in the absence of any human review.

25. In many cases, the MCOs were not aware of many of the auto-approval policies that eviCore had independently established. Rather, these auto-approvals were often established by eviCore solely for its own pecuniary benefit. For example, due to its lack of appropriate staffing and a desire not to pay for overtime work, eviCore (without MCO knowledge or approval) established auto-approvals for treatment requests submitted over certain holiday weekends.

26. By entering into these contractual arrangements with MCOs to provide utilization management and prior authorization services for Medicare Advantage, and thereby charging MCOs (acting as agents of CMS) for those services, eviCore was obligated to provide the contracted-for service. The failure to do so, without the MCOs' knowledge or approval, violates the False Claims Act.

27. Defendant eviCore's failure to perform its contracted-for utilization management and prior authorization services cost CMS and its MCOs a significant amount of money, and in certain cases, also created the opportunity for patient harm.

28. A specific example of potential patient harm caused by eviCore's actions includes the following:

a) ***Surgical***: for certain Medicare Advantage patients, Dr. Jaimie Clodfelter, D.O., an eviCore Medical Reviewer, told one of the relators in a telephone call that she is frequently asked to "sign-off" or auto-approve surgical requests even though Dr. Clodfelter is not a surgeon and does not have the professional clinical experience necessary to conduct a meaningful review of these requests.

29. Additionally, a new practice that eviCore has adopted is that when an MCO provides notice that the MCO will terminate eviCore's services, eviCore simply auto-approves everything from that departing MCO for internal cost saving purposes which violates the contract with the departing MCO and minimizes the utilization review required by the Government without disclosing such auto-approvals to the departing MCO. For example, on February 27, 2020, Marysue Agostini, Manager of MusculoSkeletal ("MSK") Specialized Therapy, indicated that due to BCBS IL Medicare's "de-implementation" (i.e., the contract with eviCore was ending) eviCore implemented auto-approval procedures.

30. Defendant eviCore failed to satisfy its contractual requirements and thus failed to provide necessary medical review functions for CMS by instituting these auto-approval policies.

31. As a result of its failure to provide any type of medical review on a large number of the cases that passed before it, Defendant eviCore knowingly provided worthless services of no

value to MCOs who stand in the shoes of CMS, thus causing MCOs to submit false claims for payment to the Government based on the assertion that eviCore was complying with the most basic and critical provisions of its subcontract.

32. Defendant eviCore thus knowingly failed to provide the medical review services that it was subcontracted to perform, thereby causing damages to the Government as CMS was not receiving the benefit of the contracted-for prior authorization and utilization management services that had been outsourced to MCOs and subcontracted to eviCore.

33. CMS would not have paid WellCare or other MCOs for prior authorization reviews, a key component of the MCOs' contracts with the Government, if it had known that the MCOs chosen subcontractor, eviCore, was providing worthless services.

34. One measure of potential damages in this case is the disgorgement of contractual payments made to Defendant eviCore, as the medical review process that eviCore had fraudulently implemented was not designed to actually perform the contracted-for services. The "reviews" eviCore did provide, often times automatic approval of anything put before it, were worthless and incapable of determining the propriety of the suggested medical care.

II. JURISDICTION AND VENUE

35. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. §§ 1331 and 1345 and 31 U.S.C. §§ 3730 and 3732(a).

36. This Court has personal jurisdiction over the Defendant because, among other things, the Defendant transacts business in this judicial district, and engaged in wrongdoing in this judicial district.

37. Venue is proper in this judicial district under 31 U.S.C. § 3732(a) and 28 U.S.C. §§ 1391(b) and (c). Defendant transacts business within this judicial district, and acts proscribed by 31 U.S.C. § 3729 occurred in this judicial district.

38. Pursuant to 31 U.S.C. § 3730(b)(2), along with its submission of the original complaint in this matter, SW Challenger prepared and has served on the Attorney General of the United States and the United States Attorney for the Southern District of New York written disclosures of all material evidence and information currently in its possession.

39. This action is not based upon prior public disclosure of allegations or transactions in a federal criminal, civil, or administrative hearing, in which the government or its agent is a party. Nor have SW Challenger's allegations or transactions herein been publicly disclosed in a congressional, Government Accountability Office, or other federal report, hearing, audit, or investigation; or in news media; or in any other form as the term "publicly disclosed" is defined in 31 U.S.C. § 3730(e)(4)(A).

40. To the extent there has been a public disclosure unknown to Relators of any of the allegations herein, Relators are the original source of those allegations within the meaning of 31 U.S.C. § 3730(e)(4)(B).

III. PARTIES

A. Plaintiffs

41. Plaintiff SW Challenger, a Delaware Limited Liability Company, brings this action on behalf of itself and the United States of America. Its principal place of business is c/o Seeger Weiss LLP, 55 Challenger Road, Ridgefield Park, NJ 07660. Among the members of SW Challenger are current and former eviCore employees (referred to herein collectively as "Relators" and individually as "Relator #1" and "Relator #2") with personal knowledge of the fraudulent

scheme alleged in this Complaint. The Relators possess personal knowledge and experience regarding eviCore's "auto-approve" activities, including personal contact with the employees and executives of eviCore who have planned, initiated and directed the violations of law alleged herein. The personal knowledge of SW Challenger is not distinct from that of the Relators.

42. Relators #1 and #2 is/was employed by eviCore as Clinical Reviewers, whose primary job responsibilities include reviewing physical therapy and occupational therapy treatment requests in the prior authorization context.

43. Relators' personal knowledge of Defendants' illegal conduct is supported by their own personal investigation undertaken to further develop and substantiate the allegations set forth in this Complaint.

44. Plaintiff, the United States of America, acting through the Department of Health and Human Services ("HHS"), and its Centers for Medicare and Medicaid Services, administers the Health Insurance Program for the Aged and Disabled established by Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.* ("Medicare"), which includes the Medicare Advantage component that is the subject of this lawsuit.

B. Defendant eviCore

45. Defendant eviCore is a Tennessee limited liability company with its principal place of business located at 400 Buckwalter Place Boulevard, Bluffton, South Carolina 29910.

46. eviCore is a direct successor to CareCore National ("CareCore"). In 2014, CareCore merged with MedSolutions, Inc., and the resulting entity rebranded itself as eviCore in 2015.

47. Between 2007 and 2013, CareCore engaged in Medicaid and Medicare fraud on a national scale, in which, as the Department of Justice reported, CareCore "blindly approved hundreds of thousands of medical procedures over a period of many years, leaving Medicare and

Medicaid to foot the bill."[1] From 2007 to 2013, CareCore improperly authorized over 200,000 outpatient diagnostic procedures, and, in 2017, paid a $54 million settlement based on that conduct. At least half of eviCore's current executive leadership team, including eviCore's Chief Executive Officer, were also in management positions at CareCore during the period 2007 to 2013.

48. As set forth in detail below, eviCore has continued its fraudulent scheme to overbill government health care programs.

49. Like its predecessor CareCore, eviCore contracts with private healthcare insurance companies to provide prior authorization and utilization management services pertaining to home health and outpatient services ordered by treating providers for the insurers' patient-beneficiaries.

50. Many of eviCore's private insurer clients are also carrier contractors under Medicare Advantage. Thus, eviCore provides prior authorization for services that are ordered for Medicare Advantage, many of which, as alleged herein, did not qualify as "covered services," yet were ultimately paid for by Medicare Advantage.

51. MCOs contracted, directly or indirectly, with eviCore.

52. MCOs delegated to eviCore the duty to make prior authorization decisions on home health and outpatient services, certain of which eviCore and MCOs knew would result in payment/reimbursement by Medicare Advantage for those services that were approved for beneficiaries.

[1] Acting U.S. Attorney Announces $54 Million Settlement of Civil Fraud Lawsuit Against Benefits Management Company for Improper Authorization Of Medical Procedures, (2017), https://www.justice.gov/usao-sdny/pr/acting-us-attorney-announces-54-million-settlement-civil-fraud-lawsuit-against-benefits.

IV. LEGAL AND REGULATORY FRAMEWORK

A. The False Claims Act

53. The False Claims Act, 31 U.S.C. § 3729, as amended, provides:

> (a) **Liability for certain acts** –
>
> (1) In general – Subject to paragraph (2), any person who –
>
> (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; [or]
>
> (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
>
> * * *
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-410), plus 3 times the amount of damages which the Government sustains because of the act of that person.

31 U.S.C. § 3729(a)(1).

54. "Knowingly" is defined by the False Claims Act as "mean[ing] that a person, with respect to information—(i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information…." 31 U.S.C. § 3729(b)(1)(A).

55. Given its remedial purposes, the False Claims Act is interpreted broadly, and is "intended to reach all types of fraud, without qualification, that might result in financial loss to the Government." *United States v. Neifert-White Co.*, 390 U.S. 228, 232 (1968).

56. The False Claims Act empowers a private person having information regarding a false or fraudulent claim against the Government to bring an action on the Government's behalf and to share in any recovery. 31 U.S.C. § 3730. The complaint must be filed under seal without

service on the defendant. *Id.* The complaint remains under seal to give the Government an opportunity to conduct an investigation into the allegations and to determine whether to join the action. *Id.*

57. Pursuant to the federal False Claims Act, the Relators seek to recover, on behalf of the United States, damages and civil penalties arising from the submission of false or fraudulent claims supported by false or misleading statements that Defendant caused to be submitted for payments, and that Defendant knew or should have known were going to be paid ultimately by government healthcare programs, including Medicare Advantage.

B. Medicare Advantage

58. Title XVIII of the Social Security Act, 42 U.S.C. § 1395, *et seq.*, establishes the federal Medicare health insurance program for the elderly and disabled. Medicare operates by authorizing payments for inpatient and outpatient healthcare services to "providers," such as hospitals, skilled nursing facilities, outpatient rehabilitation facilities, and home health agencies. 42 U.S.C. §§ 1395cc(a), 1395x(u).

59. CMS administers Medicare on behalf of the Secretary.

60. For all services and items, Medicare coverage is limited to services that are medically "reasonable and necessary." 42 U.S.C. § 1395y(a)(1).

61. Under the Medicare Part C Program, known as Medicare Advantage, the federal agency that administers the Medicare program — CMS — contracts with private health-insurance companies (known as MCOs), such as WellCare, Passport, BCBS, HCSC, HAMP, and Moda Health, that operate health-insurance plans (known as "Medicare Advantage Plans") that cover Medicare beneficiaries.

62. Pursuant to Section 1874A of the Social Security Act, Medicare may contract with eligible entities, including MCOs, to perform certain functions or parts of those functions (or, to

the extent provided in a contract, to secure performance thereof by other entities), *see* 42 U.S.C. § 1395kk-1(a), such as payment functions (including the function of developing local coverage determinations, as defined in section 1395ff(f)(2)(B)), provider services functions, and functions relating to services furnished to individuals entitled to benefits under Medicare. 42 U.S.C. § 1395kk-1(a)(4).

63. Carrier contractors, including MCOs, are obligated to perform functions under the Medicare Integrity Program, 42 U.S.C. § 1395kk-1(a), which include any or all program integrity functions described in 42 C.F.R. § 421.304, which include "(a) [c]onducting medical reviews, utilization reviews, and reviews of potential fraud related to activities of providers of services…" and "(b) [a]uditing, settling and determining cost report payments for providers of services, or other individuals or entities. . . as necessary to help ensure proper Medicare payment." *See also* 42 C.F.R. § 421.200 (specifying carrier contractor functions).

64. Carrier contractors are required to "identify and verify potential errors to produce the greatest protection to the Medicare program." Medicare Program Integrity Manual § 2.1B.

65. In addition, carrier contractors, including MCOs, are "responsible for deterring and detecting fraud and abuse." Centers for Medicare and Medicaid Services Medicare Administrative Contractor Statement of Work § C.5.13.

V. EVICORE'S FRAUDULENT CONDUCT

A. Background on eviCore's Operations and Participation in Government Healthcare Programs

66. eviCore marketed, sold, and performed, and continues to market, sell, and perform, utilization management services to determine whether services that are covered and paid for by various government health insurance programs, including Medicare Advantage, are medically reasonable and necessary.

67. eviCore specifically contracts with third-party insurance companies, such as WellCare, to perform utilization management services by providing reimbursement determinations for services ordered by physicians and allied health professionals for hundreds of thousands of covered lives, including Medicare Advantage.

68. eviCore's Clinical Reviewers are trained in the use of utilization review criteria and rules provided to eviCore by MCOs (sometimes also referred to as the "Administrative Algorithm") to assess and to screen requests for prior authorization of evaluation and treatment procedures, which requests may have been processed previously by clerical intake department staff to collect demographic data. Clinical Reviewers consider the needs of individual patients and characteristics of the local delivery system when applying the clinical criteria. eviCore's Clinical Reviewers have the authority to certify (*i.e.*, approve) requests when the clinical information provided is consistent with the utilization review criteria and standards of practice.

69. The various schemes described herein, under which eviCore provided prior authorization for services in certain cases with no review at all, not only violated eviCore's own internal policies and procedures, but, more importantly, resulted in the submission of false claims for payment of services as eviCore was providing worthless services of no value as a subcontractor on a Government-contract.

B. eviCore's Scheme – In Detail

1. Proper Prior Authorization Approvals and Denials

70. If (1) a treating provider decides that a patient requires services and (2) that patient is a beneficiary of Medicare Advantage that contracts with an MCO that in turn contracts with eviCore, then the provider or his/her office must communicate with eviCore to obtain prior authorization for the service in order to ensure that the costs of the services will be covered by Medicare Advantage.

71. This communication can be accomplished by telephoning eviCore, faxing eviCore, or using eviCore's website. Regardless of which method the provider pursues, the information is entered into a request management system maintained by eviCore, called "Image One." The Image One system prompts users – eviCore intake personnel, eviCore Clinical Reviewers, or the providers themselves – to provide some of the points of demographic and clinical information necessary for eviCore to make reimbursement determinations.

72. In addition to "Image One," eviCore employs a data analytics system called "CorePath" to manage such requests. CorePath was created to automate prior authorization requests for a wide variety of populations, conditions and diagnoses.

73. This automation is not based on valid and reliable clinical information and evidence-based clinical guidelines, but rather on criteria that do not meaningfully determine the proper need and scope for services, such as the number of visits at issue.

74. CorePath was designed to rely on insufficient clinical information in an effort to auto-approve prior authorizations regardless of scope or necessity.

75. The Image One system contains a "journal" field, which tracks the lifetime of the request in narrative form. In the context of cases "in auto-approval status," Clinical Reviewers are required to enter information into the journal explaining their approval, that either (i) does not meaningfully analyze whether the request is properly reimbursable, or (ii) is itself fraudulent.

76. When a provider uses the eviCore website to make a request, the provider himself/herself enters clinical information directly into CorePath.

77. When a prior authorization request comes in by telephone or fax and contains the information necessary to "build" the request in the CorePath system, the request is routed to intake department personnel. The intake department personnel, who are non-clinical clerks, use the

information provided to "build" the request in the CorePath system in order to enable the system to generate a prior authorization decision.

78. When a prior authorization request comes in by telephone or fax and does not contain the information necessary to "build" the request in the CorePath system, the request is routed to Clinical Reviewers.

79. Under eviCore's legal and contractual obligations, after a request for a service for a beneficiary of Medicare or Medicaid is "built" in CorePath and/or Image One, eviCore Clinical Reviewers are supposed to review the request to determine whether the service is medically necessary before prior authorization will be approved. If the clinical information that was entered into Image One is insufficient for making such a determination, then Clinical Reviewers are supposed to place the case on hold and request additional information necessary for their decision.

80. Instead of providing a meaningful review in all such cases, however, eviCore has devised a variety of interlocking schemes designed to ensure fast TAT, high rates of approval for requests (including 100% approvals for certain types of requests), and low costs of review to eviCore – by sacrificing a proper review entirely in many categories of cases.

2. Directives to Manually Auto-Approve

81. One fraudulent method by which eviCore reduces the time and money spent on its review responsibilities is to direct Clinical Reviewers to ignore acceptable standards of clinical practice, evidence-based decision making, and their own clinical judgment, and to instead simply "auto-approve" all requests relating to certain providers, therapies, and populations.

82. Clinical Reviewers follow and implement these "auto-approve" directives by simply approving whatever services a provider requests, without making an independent determination on whether those services are medically necessary or reasonable.

83. These directives are relayed from eviCore management to Clinical Reviewers through training materials, emails, and conference calls.

84. In many cases, directives to "auto-approve" certain categories of requests originated from eviCore management. eviCore is motivated to employ auto-approval procedures for a variety of reasons, including handling high volumes of requests, staff shortages, and tight TATs.

85. Upon information and belief, eviCore's contracts with insurers include key timing provisions that require eviCore to approve, partially approve, or deny provider requests within a limited time-period or pay a penalty for the late response.

86. Auto-approval also keeps review costs down by enabling eviCore to assign Clinical Reviewers to review cases outside of their scope of practice and licensure. Because cases "in auto-approval status" are to be approved regardless of need, eviCore is able to assign Clinical Reviewers to approve cases in fields in which they lack experience, knowledge, and licensure, making eviCore's staff more flexible.

87. For example, on March 23, 2018, when eviCore was "short staffed on the [occupational therapy] side," Marysue Agostini, Manager of MusculoSkeletal ("MSK") Specialized Therapy, opened review of auto-approve occupational therapy requests to all pediatric physical therapy Clinical Reviewers. It is only the auto-approval system that makes it possible for eviCore to reassign staff in this way – the review eviCore would otherwise employ would require special training and knowledge that auto-approval schemes do not require.

88. Reinforcing that "auto-approval" relieves the Clinical Reviewer of performing a meaningful review, in an October 28, 2017 email, Agostini noted: "[A]ny Passport cases with a

start date of 11/1/17 or later requires medical necessity review. A start date of 10/31/17 or before remains auto approval."

89. Defendant eviCore has actual knowledge not only of the fact that its auto-approve scheme in general does not comply with statutory requirements, but also of many discrete examples where its "auto-approve" scheme led to inappropriate authorizations of services.

90. Agostini, in a November 8, 2017 email, herself described categories of cases that Clinical Reviewers "are auto approving that ask for significantly more visits than we would approve," and requested a set of "examples of egregious requests" to use in an upcoming meeting. Agostini specifically referenced in this email a case in which a Clinical Reviewer had "to auto approve 200 visits for an ankle sprain last week."

91. Furthermore, upon information and belief, eviCore's auto-approval rubber-stamp had a large scope beyond just physical therapy services, including but not limited to the auto-approval of certain radiology services, cardiology procedures, interventional pain procedures, and laboratory management.

3. CorePath and Image One

92. eviCore has also implemented artificial intelligence systems to further streamline the fraudulent auto-approve process.

93. The auto-approval scheme discussed above is less efficient than it might be: Although the scheme prevents Clinical Reviewers from approving, partially approving, or denying cases based upon an independent determination of need, the scheme still requires a *de minimis* level of involvement from Clinical Reviewers, who must identify the request as involving a category "in auto-approval status," and then manually approve the request. The necessity of this human input makes it difficult for eviCore to scale up its review process and increase its geographical coverage range, number of covered lives, and market share.

94. To respond to this need, eviCore designed its data analytics system, CorePath. By empowering this automated system to determine whether to authorize a requested service, eviCore saves itself significant costs, avoids the risk of TAT penalties, and makes its utilization management services "scalable" – by sacrificing the meaningful review it is obligated to perform.

95. In a phone call on September 14, 2017, Bruce Brownstein, eviCore's MSK Product Advisor, advised certain pediatric Clinical Reviewers that eviCore's expansion into new business lines would increase the number of requests submitted to eviCore to a point where it would be impossible for Clinical Reviewers making determinations to keep up with the greater volume. Brownstein further advised that he was working on a CorePath AI process specific to pediatric occupational and physical therapy, which would automatically approve the first and second such requests from a provider without any clinical review. The first provider request in this context would be automatically approved. To design criteria to enable the AI to handle the second request from a provider in this context, Brownstein sought, and received, assistance from certain pediatric Clinical Reviewers.

96. In an October 26, 2017 email, Rocco Labbadia, eviCore Vice President for Clinical Content and Integration, circulated a document describing the CorePath system. This document stated that CorePath would require providers to respond only to a "limited set of clinical questions" during the request for care, and explained CorePath's main goals: "[i]t is a primary intention of CorePath to ***resolve a high majority of episodes of care without requiring any practitioner review*** or additional clinical information outside of the pathways" (emphasis added). CorePath would avoid practitioner review by mechanically approving services requests on its own.

97. In a phone call on September 15, 2018, Labbadia represented that Brownstein's automated process for pediatric therapy requests was designed with the goal of making eviCore's

utilization review "scalable," *i.e.*, to enable eviCore to pursue more business lines and secure a greater market share. Labbadia stated that pediatric therapy requests had been targeted by this program because of the longer review time associated with such requests.

98. Even in those cases where the CorePath AI does not independently make the final decision as to authorizing a requested treatment, the Image One software still restricts the ability of Clinical Reviewers to conduct a meaningful review by, *e.g.*, making it technically impossible for the Clinical Reviewer to deny, or partially deny, certain categories of requests.

99. For example, on September 6, 2017, Agostini notified the review team that she had identified a logic problem in the Image One system that needed to be addressed: With regard to WellCare Florida Medicaid cases, which were subject to an "auto-approve" directive at the time, "the system should be preventing us from making adverse determinations," *i.e.*, denials, "[h]owever, this is not happening."

100. Similarly, in a March 7, 2018 email implementing a different review process for certain categories of WellCare cases that had been subject to auto-approval, Agostini noted that the change "will require an IT update as the system does not allow for these cases to be denied."

101. As of March 2019, eviCore has implemented CorePath logic processes to automatically authorize requests from healthcare providers including Affinity, Blue Cross Blue Shield, Passport, and WellCare, across states including, at least, Arkansas, Connecticut, Illinois, Kentucky, Louisiana, Maine, Missouri, Mississippi, New Mexico, New York, North Carolina, Oklahoma, South Carolina, Tennessee, and Texas.

C. eviCore's Attempts to Whitewash its Auto-Approval Schemes

102. In early February 2019, eviCore began a process of whitewashing its internal review materials to remove or obfuscate references to automatic approval. At every stage of this process, however, eviCore made it clear to Clinical Reviewers that the replacement of the "auto-

approve" language with euphemisms was not intended as a substantive change to the auto-approve process, which eviCore directed its Clinical Reviewers to continue.

103. On February 22, 2019, Agostini emailed a small group of Clinical Reviewer supervisors, advising them that "we need to update our resources and remove any language of 'auto-approval,'" and providing substitute language, such as "approve as requested," and "approve up to the benefit limit" with which to update the Administrative Algorithm and Health Plan Guide, two documents Clinical Reviewers rely upon in evaluating prior authorization requests.

104. However, after these changes to the administrative algorithm and other job aids were implemented, on March 1, 2019, an announcement to reviewers stated that these updates to the Administrative Algorithm and Health Plan Guide were "minor updates to language that don't affect algorithm."

D. eviCore's Fraudulent Scheme Caused the Submission of False Claims and Loss to the Federal Treasury

105. Once a case has been approved by eviCore, the member receives the outpatient or home health service at the facility, the facility submits the bill to the payor, and the payor pays for the service. In the case of Medicare Advantage, the Government ultimately pays for the service.

106. Accordingly, the vast majority of services that resulted from eviCore's scheme were approved for payment, performed, and reimbursed, despite the fact that none of the auto-approved cases had been properly qualified as medically reasonable and necessary, as is required for government reimbursement.

107. As a result of eviCore's scheme, CMS paid MCOs and their subcontractor, eviCore, millions of dollars to perform prior authorization reviews which either never happened or were undertaken in a sub-standard, worthless fashion.

108. By virtue of the false or fraudulent claims for payment for worthless services that Defendant knowingly submitted or caused to be presented to the Government, the United States has suffered actual damages and are entitled to recover treble damages plus a civil monetary penalty for each false claim.

109. As a result of eviCore's fraudulent conduct, CMS has been paying and continues to pay millions of dollars annually for worthless medical review services which were and are not medically appropriate. At the very least, Defendant eviCore should be disgorged of the Government payments it has fraudulently received through its sub-contracts with MCOs.

COUNT I
Violation of the Federal False Claims Act, 31 U.S.C. § 3729(a)(1)(A)
United States of America ex rel. Challenger LLC vs. eviCore

110. Relator incorporates herein by reference each and every allegation of the preceding paragraphs of this First Amended Complaint as though fully set forth herein.

111. As a result of the foregoing conduct, eviCore knowingly presented, or caused to be presented, false or fraudulent claims for payment, in violation of 31 U.S.C. § 3729(a)(1)(A).

112. The claims relevant to this Count include all claims for payment submitted by MCOs to CMS for the above-referenced prior authorization services that eviCore either never rendered, or performed in a worthless fashion, which were caused to be submitted by virtue of eviCore's scheme directly to CMS.

113. Defendant eviCore caused the submission of such false claims for payment through their client MCOs, including WellCare, knowing that those private entities were agents for CMS, and knowing that eviCore's auto-approval prior authorization system violated a key audit function that had been delegated from CMS to MCOs and then sub-contracted to eviCore.

114. All such claims for payment that eviCore caused to be submitted were false because they were for worthless prior authorization services that were not properly undertaken per the clear terms of the contract between CMS and the client MCOs.

115. eviCore had knowledge of the falsity (as defined by the False Claims Act, 31 U.S.C. § 3729(b)(1)(A)) of the MCOs claims' for payment to the Government because, in its role as utilization review manager for its insurer clients it had actual and constructive knowledge of the worthless services it was rendering as a result of its auto-approval process, and because, as utilization review manager for its insurer clients, eviCore was obligated by contract as well as under federal regulations to undertake a proper medical review of each case before it.

116. As a result of eviCore's actions as set forth above in this First Amended Complaint, the United States of America has been, and continues to be, severely damaged.

COUNT II
Violation of Federal False Claims Act, 31 U.S.C. § 3729(a)(1)(B)
United States of America ex rel. SW Challenger LLC vs. eviCore

117. Relator incorporates herein by reference each and every allegation of the preceding paragraphs of this First Amended Complaint as though fully set forth herein.

118. As a result of the foregoing conduct, eviCore knowingly made, used, or caused to be made or used, false or fraudulent records or statements material to the payment of false or fraudulent claims, in violation of 31 U.S.C. § 3729(a)(1)(B).

119. The claims relevant to this Count include all claims for payment submitted by MCOs to CMS for the above-referenced prior authorization services that eviCore either never rendered, or performed in a worthless fashion, which were caused to be submitted by virtue of eviCore's scheme directly to CMS.

120. The false or fraudulent records or statements underlying the false claims relevant to this Count include all false or fraudulent records or statements regarding eviCore's prior authorization approval process made by eviCore to its client MCOs, including WellCare, and adopted by the MCOs in communications with the Government in carrying out the scheme.

121. eviCore made false or fraudulent records or statements underlying the false claims to its client MCOs, including WellCare, knowing that the auto-approval process violated federal laws, that its client MCOs were private entities acting as agents for the federal and/or state governments, and that the worthless services rendered as a result of the auto-approval process would be material to the payment decision of the Government in regards to whether it would continue to contract with and pay its MCOs.

122. All such resulting claims for payment that eviCore caused to be submitted by its client-MCOs were false because eviCore's prior authorization process that incorporated auto-approve and CorePath AI schemes rendered eviCore's prior authorization services, and thus the services of its client MCOs, worthless such that the Government would not have otherwise paid for such fraudulent activity.

123. eviCore had knowledge (as defined by the False Claims Act, 31 U.S.C. § 3729(b)(1)(A)) of the falsity of its client MCOs' claims for payment to the Government because, in its role as utilization review manager for its insurer clients, it had actual and constructive knowledge of the fraudulent prior authorization practices that eviCore had adopted, and because as utilization review manager for its insurer clients, eviCore was obligated by contract as well as under federal regulations to ensure such prior authorization services were performed in a correct and medically appropriate fashion.

124. The United States of America, unaware of the falsity of the records or statements underlying the false claims caused to be made by eviCore, and in reliance on the accuracy of these records or statements underlying the false claims, paid its MCOs for eviCore's worthless services.

COUNT III
Violation of Federal False Claims Act, 31 U.S.C. § 3729(a)(1)(G)
United States of America ex rel. SW Challenger LLC vs. eviCore

125. Relator incorporates herein by reference each and every allegation of the preceding paragraphs of this First Amended Complaint as though fully set forth herein.

126. By virtue of the acts alleged herein, eviCore knowingly made, used or caused to be made or used false records or false statements that are material to an obligation to pay, transmit or return money to the Government.

127. As a result of eviCore's acts, the United States has been damaged, and continues to be damaged, in a substantial amount to be determined at trial, and the United States is entitled to at least $ 11,665 and up to $23,331 for each and every violation of 31 U.S.C. § 3729 arising from eviCore's unlawful conduct as described herein.

PRAYER FOR RELIEF

WHEREFORE, Relators pray that judgment be entered against Defendant, ordering as follows:

A. That Defendant cease and desist from violating 31 U.S.C. § 3729, *et seq.*;

B. That civil penalties of not less than $ 11,665 and up to $23,331 per claim as provided by 31 U.S.C. § 3729(a) and adjusted for inflation be imposed for each and every false or fraudulent claim that Defendant caused to be submitted to the United States and/or its grantees, for each false record or statement Defendant made, used, or caused to be made or used that was material to a false or fraudulent claim, that three times the amount of damages the United States sustained because of Defendants' actions also be imposed;

C. That Defendant be enjoined from concealing, removing, encumbering, or disposing of assets which may be required to pay the civil monetary penalties imposed by the Court;

D. That Defendant disgorge all sums by which it has been enriched unjustly by its wrongful conduct;

E. That Relators be awarded the maximum amount allowed pursuant to 31 U.S.C. § 3730(d) and § 3730(h);

F. That Relators be awarded all costs, including but not limited to, court costs, expert fees and all attorney fees, costs and expenses incurred by Relators in the prosecution of this suit; and

G. That Relators be granted such other and further relief as the Court deems just and proper.

JURY TRIAL DEMAND

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, SW Challenger demands a trial by jury of all issues so triable.

DATED: May 21, 2020

Respectfully submitted,

SEEGER WEISS LLP

By: _____

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Maxwell H. Kelly, Esq.
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Counsel for Plaintiff SW Challenger, LLC

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA *ex rel.* SW CHALLENGER, LLC, Plaintiffs, - against - EVICORE HEALTHCARE MSI, LLC, Defendant.	19 Civ. 2501 (VM) **ORDER**

VICTOR MARRERO, United States District Judge.

The Clerk of Court is directed to unseal the above-captioned case.

SO ORDERED.

Dated: New York, New York
10 June 2020

Victor Marrero
U.S.D.J.

AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

Southern District of New York

UNITED STATES OF AMERICA ex rel. SW CHALLENGER, LLC

Plaintiff(s)

v.

EVICORE HEALTHCARE MSI, LLC

Defendant(s)

Civil Action No. 1:19-cv-02501-VM

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* EVICORE HEALTHCARE MSI, LLC
(See Rider A)

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

David S. Stone, Esq.
Stone & Magnanini LLP
100 Connell Drive, Suite 2200
Berkeley Heights, NJ 07922

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No. 1:19-cv-02501-VM

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____

was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____

_____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____

_____ , a person of suitable age and discretion who resides there,

on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is

designated by law to accept service of process on behalf of *(name of organization)* _____

_____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify)*:

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____

Server's signature

_____

Printed name and title

_____

Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

Rider A

EVICORE HEALTHCARE MSI, LLC
c/o Corporation Service Company
2908 Poston Ave
Nashville, TN 37203

EVICORE HEALTHCARE MSI, LLC
c/o Corporation Service Company
1703 Laurel Street
Columbia, SC 29201

EVICORE HEALTHCARE MSI, LLC
400 Buckwater Place Boulevard
Bluffton, SC 29910

AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

Southern District of New York

UNITED STATES OF AMERICA ex rel. SW CHALLENGER, LLC

Plaintiff(s)

v.

EVICORE HEALTHCARE MSI, LLC

Defendant(s)

Civil Action No. 1:19-cv-02501-VM

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David S. Stone, Esq.
Stone & Magnanini LLP
100 Connell Drive, Suite 2200
Berkeley Heights, NJ 07922

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: August 28, 2020

/S/ S. James

Signature of Clerk or Deputy Clerk

Civil Action No. 1:19-cv-02501-VM

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____

was received by me on *(date)* _____ .

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❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____

_____ , a person of suitable age and discretion who resides there,

on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is

designated by law to accept service of process on behalf of *(name of organization)* _____

_____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify)*:

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____

Server's signature

_____

Printed name and title

_____

Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

Rider A

EVICORE HEALTHCARE MSI, LLC
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c/o Corporation Service Company
1703 Laurel Street
Columbia, SC 29201

EVICORE HEALTHCARE MSI, LLC
400 Buckwater Place Boulevard
Bluffton, SC 29910

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA and
the STATE OF ALASKA,
the STATE OF CALIFORNIA,
the STATE OF CONNECTICUT,
the STATE OF FLORIDA,
the STATE OF ILLINOIS,
the STATE OF LOUISIANA,
the STATE OF MICHIGAN,
the STATE OF MONTANA,
the STATE OF NEW JERSEY,
the STATE OF NEW MEXICO,
the STATE OF NEW YORK,
the STATE OF NORTH CAROLINA,
the STATE OF OKLAHOMA,
the STATE OF TENNESSEE,
the STATE OF TEXAS, and
the STATE OF WASHINGTON,

ex rel. SW CHALLENGER, LLC,
JANE DOE 1, and
JANE DOE 2,

Plaintiffs,

vs.

EVICORE HEALTHCARE MSI, LLC,

Defendant.

Case No. 19-2501

JURY TRIAL DEMANDED

SECOND AMENDED COMPLAINT FOR VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT, 31 U.S.C. § 3729, *ET SEQ.*, AND STATE LAW COUNTERPARTS

TABLE OF CONTENTS

Plaintiff, SW Challenger, LLC ("SW Challenger"), on behalf of the United States of America (the "United States") and the States of Alaska, California, Connecticut, Florida, Illinois, Louisiana, Michigan, Montana, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Tennessee, Texas, and Washington, (collectively, the "Qui Tam States"), bring this action pursuant to the Qui Tam provisions of the Federal False Claims Act, 31 U.S.C. §§ 3729, *et seq.*, as amended (the "Federal False Claims Act"), and the Qui Tam States' statutes as enumerated below, against eviCore Healthcare MSI, LLC ("eviCore"). Jane Doe 1 and Jane Doe 2 are members of SW Challenger and bring their own claims under 31 U.S.C. § 3730(h) for retaliation suffered from defendant eviCore.[1] In support thereof, Relators allege as follows:

I. SUMMARY OF FACTUAL ALLEGATIONS

1. This is an action to recover damages and civil penalties on behalf of the United States and the various Qui Tam States arising from false and/or fraudulent records, statements and claims made, used or presented and/or caused to be made, used or presented by Defendant and/or its agents or employees under the Federal False Claims Act.

2. Under the Medicare Part C Program, known as Medicare Advantage, the federal agency that administers the Medicare program — the Centers for Medicare and Medicaid Services ("CMS") — contracts with private health-insurance companies (known as managed care organizations ("MCOs")), such as WellCare Health Plans, Inc. ("WellCare"), Passport, Blue Cross Blue Shield ("BCBS"), the Health Care Service Corporation ("HCSC"), Health Alliance Medical Plan ("HAMP"), and Moda Health, that operate health-insurance plans (known as "Medicare Advantage Plans") that cover Medicare beneficiaries. In sum, Medicare Advantage Plans are a

[1] Please note that while Jane Doe 1 and Jane Doe 2's identities are being masked for purposes of this public filing, their names will be provided to Defendant eviCore at or shortly after the time of service so that eviCore can undertake a proper defense of the retaliation allegations levied against it.

type of Medicare health plan offered by a private company that contracts with Medicare to provide all of a beneficiary's Part A (Hospital Insurance) and Part B (Medical Insurance) benefits.

3. In administering government-funded Medicare Advantage Plans, as well as Medicaid Plans, MCOs are required to perform certain functions as set forth in their contractual agreements with CMS or the Qui Tam States, including those related to prior authorization and utilization management and payment processing for outpatient and home health services.

4. For Medicare Advantage, CMS pays MCOs a capitated (per enrollee) amount to provide all Part A and B benefits. In addition, CMS makes a separate payment to MCOs for providing prescription drug benefits under Medicare Part D. Payments to MCOs are adjusted for enrollees' health status and other factors.

5. MCOs then share those payments with their sub-contractors and contracted medical providers.

6. CMS may terminate an MCO's Medicare Advantage contract for, among other things, the MCO carrying out its contract with CMS in a manner that is inconsistent with the effective and efficient implementation of the Medicare Advantage program, and if the MCO commits or participates in fraudulent or abusive activities affecting the Medicare program including the submission of fraudulent data. 42 CFR § 422.504(h)(1); 42 CFR § 422.510(a)(4)(i).

7. Similar rules and regulations apply to the contracts between MCOs and the Qui Tam States for Medicaid Plans.

8. All contracts between CMS and MCOs specify that any subcontractor who is delegated part of the MCO's functions must comply with all applicable Medicare laws, regulations, and CMS instructions. 42 CFR § 422.504(i)(4)(v).

9. CMS further requires that MCO executives certify that the patient data that they submit to CMS is true and accurate. CMS requires these signed certifications as a condition of payment. If a subcontractor generates the data, the subcontractor also must certify that its patient data is true and accurate. 42 CFR § 422.504(l)(3).

10. Defendant eviCore is purportedly in the business of providing utilization management services for Medicare Advantage Plans and Medicaid Plans for outpatient and home health services. Defendant eviCore contracts with MCOs to provide utilization management services and review prior authorization requests.

11. Utilization management is a core MCO function in the administration of Medicare Advantage and Medicaid plans, making eviCore subject to Medicare Advantage requirements as articulated in Medicare Advantage regulations and related guidance. *See, e.g.*, Medicare Managed Care Manual Chapter 11 - Medicare Advantage Application Procedures and Contract Requirements 100.5 – Administrative Contracting Requirements, *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c11.pdf ("CMS . . . view[s] contracts for. . . utilization management . . . to be administrative contracts subject to MA requirements as articulated in the MA regulation and related guidance."). As such, eviCore has agreed to comply with all applicable Medicare and Medicaid laws, regulations, and CMS instructions. *Id.*

12. One of the primary reasons that MCOs contract with third-parties like eviCore to perform these Government-mandated functions is to ensure that the MCO has in place procedures and systems to determine whether a particular medical procedure is reimbursable under a Medicaid Plan or Medicare Advantage. *See, e.g.,* 42 U.S.C. § 1395y(a)(1) ("Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B for any expenses

incurred for items or services . . . which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member"). Provider claims require eviCore's prior authorization number on the claim submitted for payment of services.

13. The central purpose of this contractual arrangement, whereby eviCore provides sub-contracted medical review services to MCOs for the benefit of CMS or a Qui Tam State, is to ensure that appropriate review procedures are in place and actually followed so as to reduce waste, fraud, and abuse within Medicare Advantage and Medicaid, and thus to ensure that medical procedures which are not reimbursable are denied.

14. Defendant eviCore knowingly accepted subcontracts from MCOs to take on the responsibility of providing CMS and Qui Tam States with prior authorization and utilization management for outpatient and home health services provided pursuant to Medicare Advantage and Medicaid Plans. As such, eviCore was required to turn the same square corners in their dealings with MCOs as if they were dealing with the Government itself.

15. If eviCore agreed to contracts with MCOs to provide certain Government-mandated services, then eviCore's intentional failure to provide such services, or eviCore's use of a recklessly designed system that did not provide these services as called for by the MCOs' contracts with the Government, subjected eviCore to liability under the False Claims Act.

16. If eviCore failed to provide utilization management services and/or review prior authorization requests as contracted-for, and as a result an MCO approved treatments that were not reimbursable, that could result in patient harm and cost the Government a significant amount of taxpayer money.

17. Essentially, by entering into these agreements to provide services to MCOs, eviCore agreed to fulfill the role the MCO had in ensuring medically necessary treatments were approved and non-medically necessary treatments were denied under Medicare Advantage and Medicaid Plans.

18. As relevant here, eviCore's contracts with MCOs include a key timing provision that requires eviCore to approve, partially approve, or deny in a timely fashion each request for prior authorization to deem services to a given beneficiary as reimbursable (each request also referred to as a "case"). In many instances, the turnaround time ("TAT") to process requests for prior authorizations is only 24 to 48 hours. Failure to meet its prescribed TAT will result in contractual penalties for eviCore.

19. Defendant eviCore, however, failed to hire sufficient staff to properly service its MCO subcontracts and meet the contractual timing requirements.

20. Rather, since at least November 2016, eviCore has engaged in fraudulent activities involving its role as the gatekeeper for determining whether requested services are appropriate and reimbursable. As detailed herein, through independent efforts to keep up with the high volume of prior authorization requests for services and to avoid contractual TAT penalties, eviCore instituted a scheme simply to "auto-approve" hundreds of cases on a daily basis, reflexively deeming those services as reasonable and necessary, even though there had been no appropriate evaluation of those cases, and in some cases, no actual human evaluation of those cases whatsoever.

21. Thus, to make up for its insufficient staffing, eviCore adopted procedures to automatically approve requested medical procedures without any meaningful clinical review or any limit on the scope of the procedure or the number of procedures approved. In layman's terms, for certain cases eviCore created a swinging gate prior authorization approval process that

approved anything and everything that passed before it. In these circumstances, eviCore provided worthless services in exchange for its contractual payment to fulfill a necessary Government function that had been outsourced to MCOs and further subcontracted to eviCore.

22. Defendant eviCore specifically directed its medical personnel, internally called "Clinical Reviewers," including Relators, to "auto-approve" or "approve as requested" services in specific jurisdictions, for specific populations, and/or under specific healthcare plans, before and without any review of the propriety or medical necessity of the services.

23. These auto-approve directives, as described by eviCore to its reviewers, included, at various times, directives to Clinical Reviewers to "auto-approve" certain categories of services without any review.

24. Relators have direct personal knowledge of eviCore's conduct as it relates to the auto-approval of physical therapy treatment, but through their interactions with other reviewers working at eviCore, they learned that these procedures were not limited to physical therapy. Rather, eviCore's auto-approval rubber-stamp had a large scope, including but not limited to the auto-approval of certain ***radiology services, cardiology procedures, joint surgery, radiation therapy, interventional pain procedures, sleep therapy and laboratory management***. The risk of significant patient harm for services and procedures that are not medically necessary in these contexts is manifest.

25. In addition to the directives eviCore provided to its Clinical Reviewers, eviCore took further steps to ensure the approval of certain categories of requests by designing and implementing a data analytics system called "CorePath" that automatically approves certain requests in the absence of any human review.

26. In many cases, the MCOs were not aware of many of the auto-approval policies that eviCore had independently established. Rather, these auto-approvals were often established by eviCore solely for its own pecuniary benefit. For example, due to its lack of appropriate staffing and a desire not to pay for overtime work, eviCore (without MCO knowledge or approval) established "approve as requested" protocols for the first three requests for any course of care. This policy was introduced over the Labor Day Holiday 2018 and continued for 126 dates when queue volumes were high until July 22, 2019.

27. By entering into these contractual arrangements with MCOs to provide utilization management and prior authorization services for Medicare Advantage and Medicaid Plans, and thereby charging MCOs (acting as agents of CMS) for those services, eviCore was obligated to provide the contracted-for service. The failure to do so, without the MCOs' knowledge or approval, violates the False Claims Act.

28. Defendant eviCore's failure to perform its contracted-for utilization management and prior authorization services cost CMS, the Qui Tam States and its MCOs a significant amount of money, and in certain cases, also created the opportunity for patient harm.

29. A specific example of potential patient harm caused by eviCore's actions includes the following:

a) ***Surgical***: for certain Medicare Advantage patients, Dr. Jaimie Clodfelter, D.O., an eviCore Medical Reviewer, told one of the Relators in a telephone call that she is frequently asked to "sign-off" or review surgical requests even though Dr. Clodfelter is not a surgeon and does not have the professional clinical experience necessary to conduct a meaningful review of these requests.

30. Additionally, a new practice that eviCore has adopted occurs when an MCO provides notice that the MCO will terminate eviCore's services. In such circumstances, eviCore simply auto-approves everything from that departing MCO to ensure internal cost saving, this violating the contract with the departing MCO and minimizing the utilization review required by the Government, all without disclosing such auto-approvals to the departing MCO. An example of this scheme was an October 30, 2019 e-mail directive from eviCore's Mary Sue Agostini, who stated that BlueCross BlueShield of Texas' ("BCBS TX") submissions would be approved "as requested" (i.e., auto-approved without proper clinical review) because "it was decided to not increase the touches on our end" since the health plan was terminating its contract with eviCore and management wanted to limit the resources spent handling BCBS TX cases prior to the termination date.

31. Defendant eviCore failed to satisfy its contractual requirements and thus failed to provide necessary medical review functions for CMS and the Qui Tam States by instituting these auto-approval policies.

32. As a result of its failure to provide any type of medical review on a large number of the cases that passed before it, Defendant eviCore knowingly provided worthless services of no value to MCOs who stand in the shoes of CMS and the Qui Tam States, thus causing MCOs to submit false claims for payment to the Government based on the assertion that eviCore was complying with the most basic and critical provisions of its subcontract.

33. Defendant eviCore thus knowingly failed to provide the medical review services that it was subcontracted to perform, thereby causing damages to the Government as CMS and the Qui Tam States were not receiving the benefit of the contracted-for prior authorization and utilization management services that had been outsourced to MCOs and subcontracted to eviCore.

34. CMS and the Qui Tam States would not have paid the MCOs for prior authorization reviews, a key component of the MCOs' contracts with the Government, if it had known that the MCOs chosen subcontractor, eviCore, was providing worthless services.

35. One measure of damages in this case is the disgorgement of contractual payments made to Defendant eviCore, as the medical review process that eviCore had fraudulently implemented was not designed to actually perform the contracted-for services. The "reviews" eviCore did provide, often times automatic approval of anything put before it, were worthless and incapable of determining the propriety of the suggested medical care.

36. In addition, Jane Doe 1 and Jane Doe 2 bring this action to recover under the anti-retaliation provisions of the federal False Claims Act, 31 U.S.C. § 3730(h). eviCore took retaliatory action against Jane Doe 1 and Jane Doe 2 because they refused to engage in unlawful activity that would have violated state and federal law.

II. JURISDICTION AND VENUE

37. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. §§ 1331 and 1345 and 31 U.S.C. §§ 3730 and 3732(a). The Court has original jurisdiction over the State law claims pursuant to 31 U.S.C. § 3732(b) because this action is brought under State laws for the recovery of funds paid by the Qui Tam States and arises from the same transactions or occurrences brought on behalf of the United States under 31 U.S.C. § 3730.

38. This Court has personal jurisdiction over the Defendant because, among other things, the Defendant transacts business in this judicial district, and engaged in wrongdoing in this judicial district.

39. Venue is proper in this judicial district under 31 U.S.C. § 3732(a) and 28 U.S.C. §§ 1391(b) and (c). Defendant transacts business within this judicial district, and acts proscribed by 31 U.S.C. § 3729 occurred in this judicial district.

40. Pursuant to 31 U.S.C. § 3730(b)(2), along with its submission of the original complaint in this matter, SW Challenger prepared and has served on the Attorney General of the United States, the United States Attorney for the Southern District of New York, and the Attorneys General of the Qui Tam States written disclosures of all material evidence and information currently in its possession.

41. This action is not based upon prior public disclosure of allegations or transactions in a federal criminal, civil, or administrative hearing, in which the government or its agent is a party. Nor have Relators' allegations or transactions herein been publicly disclosed in a congressional, Government Accountability Office, or other federal report, hearing, audit, or investigation; or in news media; or in any other form as the term "publicly disclosed" is defined in 31 U.S.C. § 3730(e)(4)(A).

42. To the extent there has been a public disclosure unknown to Relators of any of the allegations herein, Relators are the original source of those allegations within the meaning of 31 U.S.C. § 3730(e)(4)(B).

III. PARTIES

A. Plaintiffs

43. Relator SW Challenger, a Delaware limited liability company, brings this action on behalf of itself, the United States of America and the Qui Tam States. Its principal place of business is c/o Seeger Weiss LLP, 55 Challenger Road, Ridgefield Park, NJ 07660. Among the members of SW Challenger are current and former eviCore employees (referred to herein

collectively as "Relators" and individually as "Relator #1" and "Relator #2") with personal knowledge of the fraudulent scheme alleged in this Complaint. The Relators possess personal knowledge and experience regarding eviCore's "auto-approve" activities, including personal contact with the employees and executives of eviCore who have planned, initiated and directed the violations of law alleged herein. The personal knowledge of SW Challenger is not distinct from that of the Relators.

44. Relators #1 and #2 (also referred to as Jane Doe 1 and Jane Doe 2 for purposes of their personal retaliation claims raised in this Second Amended Complaint) are/were employed by eviCore as Clinical Reviewers, whose primary job responsibilities include reviewing physical therapy and occupational therapy treatment requests in the prior authorization context.

45. Jane Doe 1 and Jane Doe 2 were wrongfully retaliated against by eviCore after urging reforms to prevent eviCore from engaging in the unlawful activities that resulted in the illegal approval of medical services. Prior to filing this Complaint, Jane Doe 1 and Jane Doe 2 brought allegations of the wrongdoing described in this Complaint (i.e., those relating to eviCore's auto-approval scheme) to the attention of eviCore's executives and warned them that eviCore's failure to correct the auto-approval policies constituted fraudulent conduct.

46. Jane Doe 1 and Jane Doe 2 reasonably believed that eviCore's knowing failure to perform a full medical review of all treatment requests intentionally induced the Government to pay claims under false pretenses.

47. eviCore retaliated and discriminated against Jane Doe 1 and Jane Doe 2 because of their protected conduct under the FCA.

48. Relators' personal knowledge of Defendants' illegal conduct is supported by their own personal investigation undertaken to further develop and substantiate the allegations set forth in this Complaint.

49. Plaintiff, the United States of America, acting through the Department of Health and Human Services ("HHS"), and its Centers for Medicare and Medicaid Services, administers the Health Insurance Program for the Aged and Disabled established by Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.* ("Medicare"), which includes the Medicare Advantage component that is the subject of this lawsuit.

50. Plaintiffs Qui Tam States participate in the Medicaid program and have State False Claims Acts which permit private persons, such as Relators, to sue on their behalf to recover for false and fraudulent claims submitted for payment by Medicaid programs and/or other government healthcare programs.

B. Defendant eviCore

51. Defendant eviCore is a Tennessee limited liability company with its principal place of business located at 400 Buckwalter Place Boulevard, Bluffton, South Carolina 29910.

52. eviCore is a direct successor to CareCore National ("CareCore"). In 2014, CareCore merged with MedSolutions, Inc., and the resulting entity rebranded itself as eviCore in 2015.

53. Between 2007 and 2013, CareCore engaged in Medicaid and Medicare fraud on a national scale, in which, as the Department of Justice reported, CareCore "blindly approved hundreds of thousands of medical procedures over a period of many years, leaving Medicare and

Medicaid to foot the bill."[2] From 2007 to 2013, CareCore improperly authorized over 200,000 outpatient diagnostic procedures, and, in 2017, paid a $54 million settlement based on that conduct. At least half of eviCore's current executive leadership team, including eviCore's Chief Executive Officer, were also in management positions at CareCore during the period 2007 to 2013.

54. As set forth in detail below, eviCore has continued its fraudulent scheme to overbill government health care programs.

55. Like its predecessor CareCore, eviCore contracts with private healthcare insurance companies to provide prior authorization and utilization management services pertaining to home health and outpatient services ordered by treating providers for the insurers' patient-beneficiaries.

56. Many of eviCore's private insurer clients are also carrier contractors under Medicare Advantage and Medicaid Plans. Thus, eviCore provides prior authorization for services that are ordered for Medicare Advantage and Medicaid Plans, many of which, as alleged herein, did not qualify as "covered services," yet were ultimately paid for by Medicare Advantage and Medicaid Plans.

57. MCOs contracted, directly or indirectly, with eviCore.

58. MCOs delegated to eviCore the duty to make prior authorization decisions on home health and outpatient services, certain of which eviCore and MCOs knew would result in payment/reimbursement by Medicare Advantage and Medicaid Plans for those services that were approved for beneficiaries.

[2] Acting U.S. Attorney Announces $54 Million Settlement of Civil Fraud Lawsuit Against Benefits Management Company for Improper Authorization Of Medical Procedures, (2017), https://www.justice.gov/usao-sdny/pr/acting-us-attorney-announces-54-million-settlement-civil-fraud-lawsuit-against-benefits.

IV. LEGAL AND REGULATORY FRAMEWORK

A. The False Claims Act

59. The False Claims Act, 31 U.S.C. § 3729, as amended, provides:

> (a) **Liability for certain acts** –
>
> (1) In general – Subject to paragraph (2), any person who –
>
> (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; [or]
>
> (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
>
> * * *
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-410), plus 3 times the amount of damages which the Government sustains because of the act of that person.

31 U.S.C. § 3729(a)(l).

60. "Knowingly" is defined by the False Claims Act as "mean[ing] that a person, with respect to information—(i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information…." 31 U.S.C. § 3729(b)(1)(A).

61. Given its remedial purposes, the False Claims Act is interpreted broadly, and is "intended to reach all types of fraud, without qualification, that might result in financial loss to the Government." *United States v. Neifert-White Co.*, 390 U.S. 228, 232 (1968).

62. The False Claims Act empowers a private person having information regarding a false or fraudulent claim against the Government to bring an action on the Government's behalf and to share in any recovery. 31 U.S.C. § 3730. The complaint must be filed under seal without

service on the defendant. *Id.* The complaint remains under seal to give the Government an opportunity to conduct an investigation into the allegations and to determine whether to join the action. *Id.*

63. Pursuant to the federal False Claims Act, and its state law counterparts, the Relators seek to recover, on behalf of the United States and the Qui Tam States, damages and civil penalties arising from the submission of false or fraudulent claims supported by false or misleading statements that Defendant caused to be submitted for payments, and that Defendant knew or should have known were going to be paid ultimately by government healthcare programs, including Medicare Advantage and Medicaid Plans.

B. Medicare Advantage

64. Title XVIII of the Social Security Act, 42 U.S.C. § 1395, *et seq*., establishes the federal Medicare health insurance program for the elderly and disabled. Medicare operates by authorizing payments for inpatient and outpatient healthcare services to "providers," such as hospitals, skilled nursing facilities, outpatient rehabilitation facilities, and home health agencies. 42 U.S.C. §§ 1395cc(a), 1395x(u).

65. CMS administers Medicare on behalf of the Secretary.

66. For all services and items, Medicare coverage is limited to services that are medically "reasonable and necessary." 42 U.S.C. § 1395y(a)(1).

67. Under the Medicare Part C Program, known as Medicare Advantage, the federal agency that administers the Medicare program — CMS — contracts with private health-insurance companies (known as MCOs), such as WellCare, Passport, BCBS, HCSC, HAMP, and Moda Health, that operate health-insurance plans (known as "Medicare Advantage Plans") that cover Medicare beneficiaries.

68. Pursuant to Section 1874A of the Social Security Act, Medicare may contract with eligible entities, including MCOs, to perform certain functions or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities), *see* 42 U.S.C. § 1395kk-1(a), such as payment functions (including the function of developing local coverage determinations, as defined in section 1395ff(f)(2)(B)), provider services functions, and functions relating to services furnished to individuals entitled to benefits under Medicare. 42 U.S.C. § 1395kk-1(a)(4).

69. Carrier contractors, including MCOs, are obligated to perform functions under the Medicare Integrity Program, 42 U.S.C. § 1395kk-1(a), which include any or all program integrity functions described in 42 C.F.R. § 421.304, which include "(a) [c]onducting medical reviews, utilization reviews, and reviews of potential fraud related to activities of providers of services…" and "(b) [a]uditing, settling and determining cost report payments for providers of services, or other individuals or entities. . . as necessary to help ensure proper Medicare payment." *See also* 42 C.F.R. § 421.200 (specifying carrier contractor functions).

70. Carrier contractors are required to "identify and verify potential errors to produce the greatest protection to the Medicare program." Medicare Program Integrity Manual § 2.1B.

71. In addition, carrier contractors, including MCOs, are "responsible for deterring and detecting fraud and abuse." Centers for Medicare and Medicaid Services Medicare Administrative Contractor Statement of Work § C.5.13.

C. Medicaid

72. The Medicaid Program, as enacted by Title XIX of the Social Security Act of 1965, 42 U.S.C. § 1396, *et seq*., is a joint federal-state program that provides health care benefits for certain groups, primarily indigent and disabled individuals.

73. This cooperative federal-state Medicaid program directs federal funding to participating states to provide medical assistance to "families with dependent children and of aged, blind and disabled individuals, whose income and resources are insufficient to meet the costs of ***necessary*** medical services." 42 U.S.C. § 1396-1 (emphasis added).

74. The federal portion of each state's Medicaid payments, known as the Federal Medical Assistance Percentage ("FMAP"), is based on a state's per capita income compared to the national average. 42 U.S.C. § 1396d(b).

75. The Medicaid statute requires each participating state to implement and administer a state plan for medical assistance services which contains certain specified minimum criteria for coverage and payment of claims. 42 U.S.C. §§ 1396, 1396a(a)(10).

76. To prevent Medicaid from paying for unnecessary services, 42 U.S.C. § 1396a(a)(30)(A) requires states to maintain "methods and procedures" to "safeguard against unnecessary utilization" of Medicaid care and services.

77. Although the standard of "medical necessity" is not explicitly denoted in the Medicaid Act, it has become a judicially accepted component of the federal legislative scheme. *See, e.g., Beal v. Doe*, 432 U.S. 438, 444 (1977).

78. It is consistent with Medicaid objectives "for a State to refuse to fund *unnecessary* – though perhaps desirable – medical services." *Beal*, 432 U.S. at 444-45 (emphasis in original).

79. Each state can limit Medicaid services, if it chooses, to meet a state-created definition of medical necessity. *See* 42 C.F.R. § 440.230(d) ("The [Medicaid] agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.").

80. Many states have further defined medical necessity related to coverage under Medicaid by state statute, code or other regulatory provision.

81. Further, state Medicaid agencies are required to perform audits to implement a Statewide surveillance and utilization control program:

> The Medicaid agency must implement a statewide surveillance and utilization control program that—
>
> (a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;
>
> (b) Assesses the quality of those services;
>
> (c) Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part; and
>
> (d) Provides for the control of the utilization of inpatient services in accordance with subparts C through I of this part.

42 C.F.R. § 456.3.

82. As with Medicare, state Medicaid agencies can delegate their duties to private insurance carrier contractors, including MCOs, with which they also contract to administer health plans under state Medicaid managed care programs. *See* 42 C.F.R. § 434.6. Those delegated duties may include the determination as to whether services requested by a provider are medically necessary and appropriate.

83. In addition to the above, the Qui Tam States have enacted state Medicaid laws or regulations governing, among other things, medical necessity, program quality assurance/auditing functions of carrier contractors, and subcontractor requirements. These include:

a. Alaska:

   i. ALASKA STAT. § 21.07.250(18) (medical necessity);

   ii. ALASKA STAT. § 21.07.020 (required contract provisions for managed care plans).

b. California:

i. California Title 22 CALIFORNIA CODE OF REGULATIONS (CCR) Section 51303 (medical necessity)

ii. Title 22 CCR 53904 (contracting).

c. Connecticut:

i. CONN. GEN. STAT. § 17b-259b (medical necessity);

ii. Conn. Gen. Stat. § 17b-28b (contracting);

iii. CONN. GEN. STAT. § 17b-267 (quality assurance/auditing).

d. Florida:

i. FLA. ADMIN. CODE ANN. r. 59G-1.010(166) (medical necessity);

ii. FLA. ADMIN. CODE ANN. r. 59G-8.100(9) (quality assurance/auditing); and

iii. FLA. ADMIN. CODE ANN. r. 59G-8.100(2)(c), Fla. Admin. Code Ann. r. 59G-8.100(13) (subcontractor requirements).

e. Illinois:

i. 215 ILL. COMP. STAT. 105/2; ILL. ADMIN. CODE, tit. 89, § 140.2 (medical necessity); and

ii. 215 ILL. COMP. STAT. 134/80 (quality assurance/auditing).

f. Louisiana:

i. LA. ADMIN. CODE tit. 50, pt. I, § 1101 (medical necessity definition and criteria);

ii. LA. REV. STAT. ANN. §§ 40:2211, 40:2221 (contracting); and

iii. LA. ADMIN. CODE tit. 50, pt. I, § 3305 (contracting and utilization management).

g. Michigan:

i. MICH. COMP. LAWS ANN. § 400.111a (medical necessity);

ii. MICH. COMP. LAWS ANN. § 333.26368.III.A.12 (quality assurance/ auditing as to subcontractors' arrangements with Medicaid managed care companies); and

iii. MICH. COMP. LAWS ANN. § 333.26368.IV.H (ability to subcontract duties).

h. Montana:

i. MONT. CODE. ANN. § 53-6-101(9) (necessary medical services); MONT. ADMIN. R. 37.82.102(18) (medically necessary defined); and

ii. MONT. CODE ANN. § 53-6-705(8) (quality assurance required of managed care entity); MONT. ADMIN. R. 37.85.410 (designated review organization to determine medical necessity); MONT. ADMIN. R. 37.85.414(3) (designated review organization to perform quality control).

i. New Jersey:

i. N.J. STAT. ANN. § 30:4D-5 (medical necessity);

ii. N.J. STAT. ANN. § 30:4D-12; and Contract Template between NJ Department of Human Services and Medicaid Contractor, at p. 48, http://www.nj.gov/humanservices/dmahs/info/resources/care/hmo-contract.pdf. (quality assurance/auditing); and

iii. N.J. STAT. ANN. § 30:4D-7(p), (q), (r); N.J. STAT. ANN. § 30:4D-7b - 7c; N.J. STAT. ANN. § 30:4D-8; N.J. STAT. ANN. § 30:4D-9 (ability to subcontract duties).

j. New Mexico:

i. N.M. STAT. ANN. § 27-2-12.6 (medically necessary services); N.M. ADMIN. CODE tit. 8, § 300.1.9 (medically necessary) N.M. ADMIN. CODE tit. 8, § 301.5.9 (insuring recipients receive only necessary services);

ii. N.M. ADMIN. CODE tit. 8, § 302.5 (quality control, prior authorization and utilization review); and

iii. N.M. ADMIN. CODE tit. 8, § 300.6.9 (administration through contractors); and

iv. N.M. ADMIN. CODE tit. 8, § 302.2.10(E) (contractors).

k. New York:

i. N.Y. SOC. SERV. LAW § 365-a (medical necessity);

ii. N.Y. SOC. SERV. LAW § 364-j(8), N.Y. COMP. CODES R. & REGS. tit. 10, § 98-1.12 (quality assurance/auditing); and

iii. N.Y. COMP. CODES R. & REGS. tit. 10 § 98-1.11 (subcontractor requirements).

l. North Carolina:

i. N.C. GEN. STAT. § 108A-55(a) (necessary medical care); N.C. GEN. STAT. § 108C-7 (medical necessity criteria); N.C. ADMIN. CODE tit. 10A, r. 22F.0104; and

ii. N.C. ADMIN. CODE tit. 10A, r. 22A.0101 (fiscal agents under contract are required to conduct utilization reviews).

m. Oklahoma:

i. OKLA. STAT. tit. 56, § 1002(7) (necessary medical services); OKLA. STAT. tit. 56, § 1011.2 (medically necessary services); OKLA. ADMIN. CODE § 317:30-3-1(f) (medical necessity standards); and

ii. OKLA. STAT. tit. 56, § 1010.3 (contracting for claims administration).

n. Tennessee:

i. TENN. CODE ANN. § 71-5-144 (medical necessity);

ii. TENN. CODE ANN. § 71-5-130 (quality assurance/auditing and the authority to subcontract);

o. Texas:

i. 1 TEX. ADMIN. CODE § 353.2(57) (defining medical necessity);

ii. TEX. GOV'T CODE ANN. §§ 533.002, 533.005 (contracting); and

iii. 1 TEX. ADMIN. CODE § 353.417 (managed care quality assessment required).

p. Washington:

i. WASH. REV. CODE § 74.09.010 (10) (necessary medical services); WASH. ADMIN. CODE § 182-500-0085 (prior authorization requirement based upon medical necessity); and

ii. WASH. ADMIN. CODE § 182-538-063 (subcontracting).

V. EVICORE'S FRAUDULENT CONDUCT

A. Background on eviCore's Operations and Participation in Government Healthcare Programs

84. eviCore marketed, sold, and performed, and continues to market, sell, and perform, utilization management services to determine whether services that are covered and paid for by

various government health insurance programs, including Medicare Advantage and Medicaid Plans, are medically reasonable and necessary.

85. eviCore specifically contracts with third-party insurance companies, such as WellCare, to perform utilization management services by providing reimbursement determinations for services ordered by physicians and allied health professionals for hundreds of thousands of covered lives, including Medicare Advantage and Medicaid Plans.

86. eviCore's Clinical Reviewers are trained in the use of utilization review criteria and rules provided to eviCore by MCOs (sometimes also referred to as the "Administrative Algorithm," an internal eviCore document that summarizes eviCore's interpretation of MCO rules) to assess and to screen requests for prior authorization of evaluation and treatment procedures, which requests may have been processed previously by clerical intake department staff to collect demographic data. Clinical Reviewers consider the needs of individual patients and characteristics of the local delivery system when applying the clinical criteria. eviCore's Clinical Reviewers have the authority to certify (*i.e.*, approve) requests when the clinical information provided is consistent with the utilization review criteria and standards of practice.

87. The various schemes described herein, under which eviCore provided prior authorization for services in certain cases with no review at all, not only violated eviCore's own internal policies and procedures, but, more importantly, resulted in the submission of false claims for payment of services as eviCore was providing worthless services of no value as a subcontractor on a Government-contract.

B. eviCore's Scheme – In Detail

1. Proper Prior Authorization Approvals and Denials

88. If (1) a treating provider decides that a patient requires services and (2) that patient is a beneficiary of Medicare Advantage or a Medicaid Plan that contracts with an MCO that in turn

contracts with eviCore, then the provider or his/her office must communicate with eviCore to obtain prior authorization for the service in order to ensure that the costs of the services will be covered by Medicare Advantage or a Medicaid Plan.

89. This communication can be accomplished by telephoning eviCore, faxing eviCore, or using eviCore's website. Regardless of which method the provider pursues, the information is entered into one of two request management systems maintained by eviCore, called "Image One" and "ISAAC." The Image One system prompts users – eviCore intake personnel, eviCore Clinical Reviewers, or the providers themselves – to provide some of the points of demographic and clinical information necessary for eviCore to make reimbursement determinations. The requests are entered into Image One or the alternative system, ISAAC, depending on the nature of the request (i.e., physical therapy, cardiology, radiology, etc.).

90. In addition to "Image One," eviCore employs a data analytics system called "CorePath" to manage such requests. CorePath was created to automate prior authorization requests for a wide variety of populations, conditions and diagnoses.

91. This automation is not based on valid and reliable clinical information and evidence-based clinical guidelines, but rather on criteria that do not meaningfully determine the proper need and scope for services, such as the number of visits at issue.

92. CorePath was designed to rely on insufficient clinical information in an effort to auto-approve prior authorizations regardless of scope or necessity.

93. The Image One system contains a "journal" field, which tracks the lifetime of the request in narrative form. In the context of cases "in auto-approval status," Clinical Reviewers are required to enter information into the journal explaining their approval, that either (i) does not meaningfully analyze whether the request is properly reimbursable, or (ii) is itself fraudulent.

94. When a provider uses the eviCore website to make a request, the provider himself/herself enters clinical information directly into CorePath.

95. When a prior authorization request comes in by telephone or fax and contains the information necessary to "build" the request in the CorePath system, the request is routed to intake department personnel. The intake department personnel, who are non-clinical clerks, use the information provided to "build" the request in the CorePath system in order to enable the system to generate a prior authorization decision.

96. When a prior authorization request comes in by telephone or fax and does not contain the information necessary to "build" the request in the CorePath system, the request is routed to Clinical Reviewers.

97. Under eviCore's legal and contractual obligations, after a request for a service for a beneficiary of Medicare or Medicaid is "built" in CorePath and/or Image One and/or ISAAC, eviCore Clinical Reviewers are supposed to review the request to determine whether the service is medically necessary before prior authorization will be approved. If the clinical information that was entered into Image One/ISAAC is insufficient for making such a determination, then Clinical Reviewers are supposed to place the case on hold and request additional information necessary for their decision.

98. Instead of providing a meaningful review in all such cases, however, eviCore has devised a variety of interlocking schemes designed to ensure fast TAT, high rates of approval for requests (including 100% approvals for certain types of requests), and low costs of review to eviCore – by sacrificing a proper review entirely in many categories of cases.

2. Directives to Manually Auto-Approve

99. One fraudulent method by which eviCore reduces the time and money spent on its review responsibilities is to direct Clinical Reviewers to ignore acceptable standards of clinical

practice, evidence-based decision making, and their own clinical judgment, and to instead simply "auto-approve" all requests relating to certain providers, therapies, and populations.

100. Clinical Reviewers follow and implement these "auto-approve" directives by simply approving whatever services a provider requests, without making an independent determination on whether those services are medically necessary or reasonable.

101. These directives are relayed from eviCore management to Clinical Reviewers through training materials, emails, and conference calls.

102. For example, on October 27, 2017, Relators were forwarded e-mail instructions from eviCore's David Baird, Senior Vice President of Program Operations, and Dr. Robert Westergan, Chief Medical Director, directing auto-approval for BCBS TX. Senior leadership at eviCore demanded that pediatric treatment requests be auto-approved due to "provider noise." At the time of this email, BCBS TX expected full medical necessity review of requests. However, because eviCore was receiving complaints from providers, eviCore initiated auto-approvals without MCO approval.

103. Approximately one month after this e-mail, one of the Relators attended a meeting in Waco, Texas, along with Vycki Rupakus (an eviCore provider relations representative) and Ann Jones, Vice President at BCBS TX (appearing via conference call). At that meeting, it was agreed that pediatric developmental requests would be auto-approved for a six-month period to mollify providers. Thereafter, requests would move back to traditional medical necessity review. However, eviCore never re-implemented full medical necessity review.

104. In many cases, directives to "auto-approve" certain categories of requests originated from eviCore management. eviCore is motivated to employ auto-approval procedures

for a variety of reasons, including handling high volumes of requests, staff shortages, and tight TATs, and increased profits.

105. As an example of auto-approvals done without the MCOs' knowledge or consent, in an internal eviCore document titled "Auto-Approvals (IO-CDP) 6-1-20," the document states "**Approvals by QPID-sPA-PI-UPADS are not health plan directed approvals**. These are approvals based on survey responses and other data collected by the system." (Emphasis in original). The same notation was located in another internal eviCore document titled "Auto-Approvals (ISAAC) 5-11-20."

106. Upon information and belief, eviCore's contracts with insurers include key timing provisions that require eviCore to approve, partially approve, or deny provider requests within a limited time-period or pay a penalty for the late response.

107. Auto-approval also keeps review costs down by enabling eviCore to assign Clinical Reviewers to review cases outside of their scope of practice and licensure. Because cases "in auto-approval status" are to be approved regardless of need, eviCore is able to assign Clinical Reviewers to approve cases in fields in which they lack experience, knowledge, and licensure, making eviCore's staff more flexible.

108. For example, on March 23, 2018, when eviCore was "short staffed on the [occupational therapy] side," Marysue Agostini, Manager of MusculoSkeletal ("MSK") Specialized Therapy, opened review of auto-approve occupational therapy requests to all pediatric physical therapy Clinical Reviewers. It is only the auto-approval system that makes it possible for eviCore to reassign staff in this way – the review eviCore would otherwise employ would require special training and knowledge that auto-approval schemes do not require.

109. Reinforcing that "auto-approval" relieves the Clinical Reviewer of performing a meaningful review, in an October 28, 2017 email, Agostini noted: "[A]ny Passport cases with a start date of 11/1/17 or later requires medical necessity review. A start date of 10/31/17 or before remains auto approval."

110. Defendant eviCore has actual knowledge not only of the fact that its auto-approve scheme in general does not comply with statutory requirements, but also of many discrete examples where its "auto-approve" scheme led to inappropriate authorizations of services.

111. Agostini, in a November 8, 2017 email, herself described categories of cases that Clinical Reviewers "are auto approving that ask for significantly more visits than we would approve," and requested a set of "examples of egregious requests" to use in an upcoming meeting. Agostini specifically referenced in this email a case in which a Clinical Reviewer had "to auto approve 200 visits for an ankle sprain last week."

112. Furthermore, eviCore's auto-approval rubber-stamp had a large scope beyond just physical therapy services, including but not limited to the auto-approval of certain joint surgery, radiation therapy, sleep therapy, radiology services, cardiology procedures, interventional pain procedures, and laboratory management. Indeed, internal eviCore documents, such as its nurse reviewer job aid for the ISAAC platform, outline all of the various health plans, lines of business and procedures/disciplines that are auto-approved, both with and without the knowledge of the health plan.

3. CorePath and Image One

113. eviCore has also implemented artificial intelligence systems to further streamline the fraudulent auto-approve process.

114. The auto-approval scheme discussed above is less efficient than it might be: Although the scheme prevents Clinical Reviewers from approving, partially approving, or denying

cases based upon an independent determination of need, the scheme still requires a *de minimis* level of involvement from Clinical Reviewers, who must identify the request as involving a category "in auto-approval status," and then manually approve the request. The necessity of this human input makes it difficult for eviCore to scale up its review process and increase its geographical coverage range, number of covered lives, and market share.

115. To respond to this need, eviCore designed its data analytics system, CorePath. By empowering this automated system to determine whether to authorize a requested service, eviCore saves itself significant costs, avoids the risk of TAT penalties, and makes its utilization management services "scalable" – by sacrificing the meaningful review it is obligated to perform.

116. In a phone call on September 14, 2017, Bruce Brownstein, eviCore's MSK Product Advisor, advised certain pediatric Clinical Reviewers that eviCore's expansion into new business lines would increase the number of requests submitted to eviCore to a point where it would be impossible for Clinical Reviewers making determinations to keep up with the greater volume. Brownstein further advised that he was working on a CorePath AI process specific to pediatric occupational and physical therapy, which would automatically approve the first and second such requests from a provider without any clinical review. The first provider request in this context would be automatically approved. To design criteria to enable the AI to handle the second request from a provider in this context, Brownstein sought, and received, assistance from certain pediatric Clinical Reviewers.

117. In an October 26, 2017 email, Rocco Labbadia, eviCore Vice President for Clinical Content and Integration, circulated a document describing the CorePath system. This document stated that CorePath would require providers to respond only to a "limited set of clinical questions" during the request for care, and explained CorePath's main goals: "[i]t is a primary intention of

CorePath to ***resolve a high majority of episodes of care without requiring any practitioner review*** or additional clinical information outside of the pathways" (emphasis added). CorePath would avoid practitioner review by mechanically approving services requests on its own.

118. In a phone call on September 15, 2018, Labbadia represented that Brownstein's automated process for pediatric therapy requests was designed with the goal of making eviCore's utilization review "scalable," *i.e.*, to enable eviCore to pursue more business lines and secure a greater market share. Labbadia stated that pediatric therapy requests had been targeted by this program because of the longer review time associated with such requests.

119. Even in those cases where the CorePath AI does not independently make the final decision as to authorizing a requested treatment, the Image One software still restricts the ability of Clinical Reviewers to conduct a meaningful review by, *e.g.*, making it technically impossible for the Clinical Reviewer to deny, or partially deny, certain categories of requests.

120. For example, on September 6, 2017, Agostini notified the review team that she had identified a logic problem in the Image One system that needed to be addressed: With regard to WellCare Florida Medicaid cases, which were subject to an "auto-approve" directive at the time, "the system should be preventing us from making adverse determinations," *i.e.*, denials, "[h]owever, this is not happening."

121. Similarly, in a March 7, 2018 email implementing a different review process for certain categories of WellCare cases that had been subject to auto-approval, Agostini noted that the change "will require an IT update as the system does not allow for these cases to be denied."

122. As of March 2019, eviCore has implemented CorePath logic processes to automatically authorize requests from healthcare providers including Affinity, Blue Cross Blue Shield, Passport, and WellCare, across states including, at least, Arkansas, Connecticut, Illinois,

Kentucky, Louisiana, Maine, Missouri, Mississippi, New Mexico, New York, North Carolina, Oklahoma, South Carolina, Tennessee, and Texas.

123. The CorePath scheme continues to evolve. Weekly meeting minutes from a July 23, 2019 team meeting demonstrate that eviCore's senior leadership made adjustments to CorePath to include auto-approving visits for every second request during a time of high queue volume without any clinical review.

C. eviCore's Attempts to Whitewash its Auto-Approval Schemes

124. In early February 2019, eviCore began a process of whitewashing its internal review materials to remove or obfuscate references to automatic approval. At every stage of this process, however, eviCore made it clear to Clinical Reviewers that the replacement of the "auto-approve" language with euphemisms was not intended as a substantive change to the auto-approve process, which eviCore directed its Clinical Reviewers to continue.

125. On February 22, 2019, Agostini emailed a small group of Clinical Reviewer supervisors, advising them that "**we need to update our resources and remove any language of 'auto-approval,'**" and providing substitute language, such as "approve as requested," and "approve up to the benefit limit" with which to update the Administrative Algorithm and Health Plan Guide, two documents Clinical Reviewers rely upon in evaluating prior authorization requests. (Emphasis added).

126. However, after these changes to the administrative algorithm and other job aids were implemented, on March 1, 2019, an announcement to reviewers stated that these updates to the Administrative Algorithm and Health Plan Guide were "minor updates to language that don't affect algorithm."

127. eviCore's whitewashing of its prolific use of auto-approvals is notably illustrated in the case of the Texas Medicaid program. During a WebEx meeting held on Oct 3, 2019 for a

Texas Fair Hearing involving Health Care Service Corporation (BlueCross Blue Shield of Texas), Texas Medicaid officials and eviCore personnel, eviCore's Margaret Coutts misrepresented to HCSC/BCBS TX and Texas Medicaid personnel that a review decision granting full approval (made because of eviCore's auto-approval policy) was based on an appropriate medical necessity review. Ms. Coutts did not disclose to HCSC and Texas Medicaid personnel that eviCore was auto-approving PT/OT treatment requests and instead said that a particular decision was reviewed for medical necessity (when in fact it was not).

128. In a subsequent telephone conversation, Ms. Coutts spoke with one of the Relators. In that conversation, Ms. Coutts asked the Realtor to help her craft a plausible medical necessity explanation for the auto-approval review decision she had discussed with Texas Medicaid. Essentially, after lying to Texas Medicaid officials, eviCore's Coutts wanted Relator's assistance to help medically justify an auto-approval which was never subject to proper clinical review in the first instance.

D. eviCore's Fraudulent Scheme Caused the Submission of False Claims and Loss to Federal and State Governments

129. Once a case has been approved by eviCore, the member receives the outpatient or home health service at the facility, the facility submits the bill to the payor, and the payor pays for the service. In the case of Medicare Advantage and Medicaid Plans, the Government ultimately pays for the service.

130. Accordingly, the vast majority of services that resulted from eviCore's scheme were approved for payment, performed, and reimbursed, despite the fact that none of the auto-approved cases had been properly qualified as medically reasonable and necessary, as is required for government reimbursement.

131. As a result of eviCore's scheme, CMS and the Qui Tam States paid MCOs and their subcontractor, eviCore, millions of dollars to perform prior authorization reviews which either never happened or were undertaken in a sub-standard, worthless fashion.

132. By virtue of the false or fraudulent claims for payment for worthless services that Defendant knowingly submitted or caused to be presented to the Government, the United States and the Qui Tam States have suffered actual damages and are entitled to recover treble damages plus a civil monetary penalty for each false claim.

133. As a result of eviCore's fraudulent conduct, CMS and the Qui Tam States have been paying and continue to pay millions of dollars annually for worthless medical review services which were and are not medically appropriate. At the very least, Defendant eviCore should be disgorged of the Government payments it has fraudulently received through its sub-contracts with MCOs.

E. Jane Doe 1's and Jane Doe 2's attempts to investigate and reform eviCore

134. Jane Doe 1 and Jane Doe 2 learned that eviCore was auto-approving medical services, despite its obligations to perform a full medical review to determine the appropriate care. They reasonably believed that eviCore was not complying with state and federal law and undertook to investigate and implement change within eviCore.

135. In response to Jane Doe 1's and Jane Doe 2's efforts to reform eviCore, Jane Doe 1 and Jane Doe 2 were retaliated against and, ultimately, forced to resign. Their working conditions become so intolerable that any reasonable person in the employees' position would have felt compelled to resign.

136. Indeed, a member of the Clinical Review Team confirmed on September 26, 2019 that eviCore clinical reviewers were being targeted by management as a result of voicing their

concerns about the CorePath clinical review system and auto-approval schemes, stating "[it is] like Marshall Law…don't speak up, don't make a noise, otherwise you'll get targeted [by management] —it's extremely concerning!"

137. eviCore discriminated against and marginalized Jane Doe 1 and Jane Doe 2 in direct retaliation for their investigative activities and having come forward to report eviCore's unlawful auto-approval schemes.

138. eviCore knew that Jane Doe 1 and Jane Doe 2 were engaged in conduct protected under the FCA. The FCA's anti-retaliation provision, 31 U.S.C. § 3730(h), prohibits discrimination against a person in the terms and conditions of employment because of that person's efforts in furtherance of an action under that statute or efforts to stop one or more violations of the federal False Claims Act. A person retaliated against in violation of this section is entitled to reinstatement, double the amount of lost back pay, interest on the back pay, and special damages, including attorney fees and litigation costs.

1. Jane Doe 1

139. Jane Doe 1 began working for eviCore on July 17, 2017 as a Clinical Reviewer and was tasked with improving eviCore's pediatric guidelines for therapy directions. As a part of her training, Jane Doe 1 was assigned to health plans that were "auto-approvals" in order to familiarize herself with eviCore's approval pathway system, Image One.

140. As a result of her experience and expertise, Jane Doe 1 was assigned to work on higher-level projects within her role. For example, her work involved updating and developing pediatric guidelines, to be approved by the Medical Advisory Board, and health plans to help guide authorization decisions. By the nature of her role, Jane Doe 1 was in direct contact with the authorization process at eviCore and was put in a position to critically analyze, develop, and improve that process.

141. In mid-September 2017, Jane Doe 1 worked on a team with Jane Doe 2 to develop a pediatric pathway for eviCore's new data analytics system, CorePath.

142. From October 2017 through January 2018, Jane Doe 1 lead a team of pediatric reviewers to develop an authorization decision matrix, based on current medical evidence, literature, and guidelines. This was a high-level project, in which Jane Doe 1 developed pediatric administrative and clinical algorithms to be implemented into the approval process.

143. Jane Doe 1 was also asked to travel to represent eviCore and educate providers across the country. For example, on October 24, 2017, Jane Doe 1 officially represented eviCore during paid travel to Orlando, Florida to provide on-site education at United Cerebral Palsy of Central Florida.

144. In January 2018, Jane Doe 1 was selected to join the "Blue Ribbon" Team to update clinical review job aids and administrative algorithms. She maintained these updates until approximately January 2020, when Danna Mullins took over the project. It was while working on this project that Jane Doe 1 discovered the compliance whitewashing and auto-approval terminology from job aids.

145. On February 8, 2019, as part of her effort to reform eviCore, Jane Doe 1 sent an email to eviCore's Compliance Department in which she reported her legal, professional, and ethical concerns regarding eviCore's systematic and excessive auto-approvals for treatment authorizations.

146. On February 22, 2019, in response to her email, Jane Doe 1 discovered that Compliance instructed “auto-approval” language to be removed from job aids, but the clinical review auto-approve process was not to change. Jane Doe 1 identified this action as corporate whitewashing.

147. On March 13, 2019 and March 15, 2019, Jane Doe 1 participated in two meetings between eviCore and WellCare senior management, in which she voiced her concerns about excessive auto-approvals and the patient-harm that is caused by the "all-or-nothing" approach to auto-approving all initial treatment plans.

148. Shortly after she voiced her ethical concerns to eviCore's Compliance Department and during the March 2019 meetings with WellCare, and rather than expressing gratitude to Jane Doe 1 for coming forward and seeking to reform eviCore, eviCore management retaliated against Jane Doe 1 by intentionally targeting her with unreasonable and uncommon productivity requirements, which in effect guaranteed her exclusion from future merit-based assignments to high-level projects. Among other things, on March 18, 2019, Jane Doe 1 received a phone call from her direct manager, Margaret Coutts, who informed her that Mary Mateo instructed that Jane Doe 1 was no longer allowed to take meeting requests or projects without first checking with her direct manager.

149. From May 2019 to her resignation, Jane Doe 1's role within eviCore was limited to only reviewing prior authorizations. During the onset of COVID-19, the workload for reviewing authorizations was substantially reduced, and a notice was sent out to employees that they were not expected to reach prior productivity goals. Shortly after receiving this email, however, Jane Doe 1 received a verbal warning from Margaret Coutts that she had to meet her original productivity requirement.

150. After withstanding this targeted retaliation, harassment, and marginalization because she pushed back against eviCore's unlawful auto-approval schemes, Jane Doe 1 was forced to resign from eviCore on March 20, 2020.

2. Jane Doe 2

151. Jane Doe 2 began employment with eviCore on November 7, 2016 as a Clinical Reviewer.

152. In mid-September 2017, Jane Doe 2 worked on a team with Jane Doe 1 to develop a pediatric pathway for eviCore's new data analytics system, CorePath, that would allow eviCore to scale the clinical review process without hiring additional personnel, specifically by allowing treatment to be "auto-approved" without the case being touched by a Clinical Reviewer.

153. On September 15, 2017, during a call with Rocco Labbadia, Jane Doe 2 voiced her concern about whether, given the complexity of pediatric decisions, a data analytics system could effectively make the same evidence-based review decisions that a Clinical Reviewer would make, as required by law.

154. After Jane Doe 2 raised her concerns with eviCore management, she was promptly removed from meetings with the team, who eventually completed the CorePath system for non-Clinical Review.

155. Rather than expressing gratitude to Jane Doe 2 for coming forward and seeking to reform eviCore, Jane Doe 2 was passed over for managerial promotions from within the Clinical Review Team because she had expressed her concern about the creation of CorePath.

156. In September 2019, after completing monthly audits of the pediatric PT Clinical Reviewers, Jane Doe 2 notified audit manager, Pam Govender, and Manager of Clinical Review, MarySue Agostini, that she believed an audit decision required additional information from the provider.

157. During a September 27, 2019 phone call with Jane Doe 2 and Margaret Coutts, eviCore's Director of Therapy, Laura Walters-Bietz, reprimanded Jane Doe 2 for "directing care" by recommending a consultative plan to a provider during a peer-to-peer call.

158. The following week after this phone call, Jane Doe 2 was removed from Complex Case Management and Audit teams and Consultations teams.

159. On March 27, 2020, the Clinical Review Team was notified that a new review process was being implemented, Episodic Authorization/Extended Model.

160. On March 29, 2020, Jane Doe 2 reported ethical concerns about the excessive auto-approvals to eviCore's Compliance Department, and that she was concerned about her "culpability in approving care that could be potentially harmful to pediatric and adult patients, fraudulent, wasteful or abusive to the health care system."

161. In February and March 2020, as described above, the Clinical Review queue volume decreased dramatically in response to an influx of additional reviewers and the COVID-19 pandemic. On April 9, 2020, Mary Mateo sent out an email to the MSK Therapies PT/OT/ST Team, confirming that management would not be implementing the normal productivity requirements and productivity would not be tracked due to the low volume of treatment requests due to the COVID-19 pandemic.

162. Yet, like Jane Doe 1, Jane Doe 2 received an email from Margaret Coutts containing a verbal warning about her low productivity, even though productivity expectations were lowered for the rest of the Clinical Review Team.

163. After withstanding this targeted retaliation, harassment, and marginalization because she pushed back against eviCore's unlawful auto-approval schemes, Jane Doe 2 was forced to resign from eviCore on May 26, 2020.

164. eviCore's retaliatory acts were, not coincidentally, taken shortly after Jane Doe 1 and Jane Doe 2 raised their concerns about the illegal conduct. eviCore's wrongful conduct was

made in direct violation of the False Claims Act's prohibition against such retaliation. See 31 U.S.C. § 3730(h).

165. As a direct and proximate result of this unlawful retaliation, Jane Doe 1 and Jane Doe 2 have suffered emotional pain and mental anguish, together with serious economic damages.

COUNT I
Violation of the Federal False Claims Act, 31 U.S.C. § 3729(a)(1)(A)
United States of America ex rel. Challenger LLC vs. eviCore

166. Relator incorporates herein by reference each and every allegation of the preceding paragraphs of this Second Amended Complaint as though fully set forth herein.

167. As a result of the foregoing conduct, eviCore knowingly presented, or caused to be presented, false or fraudulent claims for payment, in violation of 31 U.S.C. § 3729(a)(1)(A).

168. The claims relevant to this Count include all claims for payment submitted by MCOs to CMS for the above-referenced prior authorization services that eviCore either never rendered, or performed in a worthless fashion, which were caused to be submitted by virtue of eviCore's scheme directly to CMS.

169. Defendant eviCore caused the submission of such false claims for payment through their client MCOs, knowing that those private entities were agents for CMS, and knowing that eviCore's auto-approval prior authorization system violated a key audit function that had been delegated from CMS to MCOs and then sub-contracted to eviCore.

170. All such claims for payment that eviCore caused to be submitted were false because they were for worthless prior authorization services that were not properly undertaken per the clear terms of the contract between CMS and the client MCOs.

171. eviCore had knowledge of the falsity (as defined by the False Claims Act, 31 U.S.C. § 3729(b)(1)(A)) of the MCOs claims' for payment to the Government because, in its role as

utilization review manager for its insurer clients it had actual and constructive knowledge of the worthless services it was rendering as a result of its auto-approval process, and because, as utilization review manager for its insurer clients, eviCore was obligated by contract as well as under federal regulations to undertake a proper medical review of each case before it.

172. As a result of eviCore's actions as set forth above in this Second Amended Complaint, the United States of America has been, and continues to be, severely damaged.

COUNT II
Violation of Federal False Claims Act, 31 U.S.C. § 3729(a)(1)(B)
United States of America ex rel. SW Challenger LLC vs. eviCore

173. Relator incorporates herein by reference each and every allegation of the preceding paragraphs of this Second Amended Complaint as though fully set forth herein.

174. As a result of the foregoing conduct, eviCore knowingly made, used, or caused to be made or used, false or fraudulent records or statements material to the payment of false or fraudulent claims, in violation of 31 U.S.C. § 3729(a)(1)(B).

175. The claims relevant to this Count include all claims for payment submitted by MCOs to CMS for the above-referenced prior authorization services that eviCore either never rendered, or performed in a worthless fashion, which were caused to be submitted by virtue of eviCore's scheme directly to CMS.

176. The false or fraudulent records or statements underlying the false claims relevant to this Count include all false or fraudulent records or statements regarding eviCore's prior authorization approval process made by eviCore to its client MCOs and adopted by the MCOs in communications with the Government in carrying out the scheme.

177. eviCore made false or fraudulent records or statements underlying the false claims to its client MCOs, knowing that the auto-approval process violated federal laws, that its client

MCOs were private entities acting as agents for the federal and/or state governments, and that the worthless services rendered as a result of the auto-approval process would be material to the payment decision of the Government in regards to whether it would continue to contract with and pay its MCOs.

178. All such resulting claims for payment that eviCore caused to be submitted by its client-MCOs were false because eviCore's prior authorization process that incorporated auto-approve and CorePath AI schemes rendered eviCore's prior authorization services, and thus the services of its client MCOs, worthless such that the Government would not have otherwise paid for such fraudulent activity.

179. eviCore had knowledge (as defined by the False Claims Act, 31 U.S.C. § 3729(b)(1)(A)) of the falsity of its client MCOs' claims for payment to the Government because, in its role as utilization review manager for its insurer clients, it had actual and constructive knowledge of the fraudulent prior authorization practices that eviCore had adopted, and because as utilization review manager for its insurer clients, eviCore was obligated by contract as well as under federal regulations to ensure such prior authorization services were performed in a correct and medically appropriate fashion.

180. The United States of America, unaware of the falsity of the records or statements underlying the false claims caused to be made by eviCore, and in reliance on the accuracy of these records or statements underlying the false claims, paid its MCOs for eviCore's worthless services.

COUNT III
Violation of Federal False Claims Act, 31 U.S.C. § 3729(a)(1)(G)
United States of America ex rel. SW Challenger LLC vs. eviCore

181. Relator incorporates herein by reference each and every allegation of the preceding paragraphs of this Second Amended Complaint as though fully set forth herein.

182. By virtue of the acts alleged herein, eviCore knowingly made, used or caused to be made or used false records or false statements that are material to an obligation to pay, transmit or return money to the Government.

183. As a result of eviCore's acts, the United States has been damaged, and continues to be damaged, in a substantial amount to be determined at trial, and the United States is entitled to at least $ 11,665 and up to $23,331 for each and every violation of 31 U.S.C. § 3729 arising from eviCore's unlawful conduct as described herein

COUNT IV
Violation of Federal False Claims Act, 31 U.S.C. § 3729(a)(1)(C)
United States of America ex rel. SW Challenger LLC vs. eviCore

184. Relator realleges and hereby incorporates by reference each and every allegation contained in the preceding paragraphs of this Second Amended Complaint.

185. eviCore conspired with others to implement "auto-approval" procedures such that certain of the services that eviCore was being paid by the Government to render were either never rendered, or performed in a worthless fashion.

186. Accordingly, eviCore and others conspired to defraud the Government by (a) getting false or fraudulent claims allowed or paid, and/or (b) committing a violation of the FCA, in violation of 31 U.S.C. § 3729(a). By virtue of the false or fraudulent claims submitted, paid, or approved as a result of eviCore's conspiracy to defraud the Government, the United States has suffered substantial monetary damages.

COUNT V
Violation of Alaska Medical Assistance False Claims and Reporting Act
State of Alaska vs. eviCore

184. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein.

185. This is a civil action brought by Relator on behalf of the State of Alaska against Defendant eviCore, under the Alaska Medical Assistance False Claims and Reporting Act, Alaska Stat. § 09.58.010 et seq.

186. The State of Alaska and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Alaska.

187. One or more MCOs, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services.

188. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, to officers or employees of the State of Alaska or one of its agencies false or fraudulent claims for payment or approval, in violation of Alaska Stat. § 09.58.010 et seq.

189. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used, or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements to secure the payment or approval by the State of Alaska, or its political subdivisions, false records or statements material to false or fraudulent claims, in violation of Alaska Stat. § 09.58.010 *et seq*.

190. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, and with actual knowledge of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false

records or statements to conceal, avoid, or decrease an obligation to pay or transmit money to the State of Alaska, or its political subdivisions, in violation of Alaska Stat. § 09.58.010 *et seq*.

191. The State of Alaska and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

192. As a result of Defendants' actions, as set forth above, the State of Alaska and/or its agencies or political subdivisions have been, and may continue to be, severely damaged

COUNT VI
Violation of California False Claims Act
State of California vs. eviCore

193. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein.

194. This is a civil action brought by Relator on behalf of the State of California against Defendant eviCore, under the California False Claims Act, Cal. Gov't Code § 12650, *et seq.*

195. The State of California and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in California.

196. One or more MCOs, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services.

197. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, to

officers or employees of the State of California or one of its agencies false or fraudulent claims for payment or approval, in violation of Cal. Gov't Code § 12650, *et seq.*

198. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used, or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements to secure the payment or approval by the State of California, or its political subdivisions, false records or statements material to false or fraudulent claims, in violation of Cal. Gov't Code § 12650, *et seq.*

199. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, and with actual knowledge of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements to conceal, avoid, or decrease an obligation to pay or transmit money to the State of California, or its political subdivisions, in violation of Cal. Gov't Code § 12650, *et seq.*.

200. The State of California and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

201. As a result of Defendants' actions, as set forth above, the State of California and/or its agencies or political subdivisions have been, and may continue to be, severely damaged

COUNT VII
Violation of Connecticut False Claims Act
State of Connecticut vs. eviCore

202. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein.

203. This is a civil action brought by Relator on behalf of the State of Connecticut against Defendant eviCore, under the State of Connecticut's False Claims Act for Medical Assistance Programs, Conn. Gen. Stat. § 4-277.

204. The State of Connecticut and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Connecticut.

205. One or more MCOs, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services.

206. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, to officers or employees of the State of Connecticut or one of its agencies false or fraudulent claims for payment or approval under a medical assistance program administered by the Department of Social Services, in violation of Conn. Gen. Stat. § 4-275(a)(1).

207. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used, or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements to secure the payment or approval by the State of Connecticut, or its political subdivisions, false or fraudulent claims under a medical assistance program administered by the Department of Social Services, in violation of Conn. Gen. Stat. § 4-275(a)(2).

208. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, and with actual knowledge of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements to conceal, avoid, or decrease an obligation to pay or transmit money to the State of Connecticut, or its political subdivisions, under a medical assistance program administered by the Department of Social Services, in violation of Conn. Gen. Stat. § 4-275(a)(7).

209. The State of Connecticut and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

210. As a result of Defendants' actions, as set forth above, the State of Connecticut and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT VIII
Violation of Florida False Claims Act
State of Florida vs. eviCore

211. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein.

212. This is a civil action brought by Relator on behalf of the State of Florida against Defendant eviCore, under the State of Florida's False Claims Act, FLA. STAT. ANN. § 68.083(2).

213. The State of Florida and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Florida.

214. One or more MCOs, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services.

215. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, to officers or employees of the State of Florida or one of its agencies false or fraudulent claims for payment or approval, in violation of FLA. STAT. ANN. § 68.082(2)(a).

216. eviCore in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used, or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements to get false or fraudulent claims paid or approved by the State of Florida or one of its agencies, in violation of FLA. STAT. ANN. § 68.082(2)(b).

217. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements to conceal, avoid, or decrease an obligation to pay or transmit money to the State of Florida or one of its agencies, in violation of FLA. STAT. ANN. § 68.082 (2)(g).

218. The State of Florida and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

219. As a result of Defendant's actions, as set forth above, the State of Florida and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT IX
Violation of Illinois False Claims Act
State of Illinois vs. eviCore

220. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein.

221. This is a civil action brought by Relator on behalf of the State of Illinois against Defendant eviCore, under the Illinois False Claims Act, 740 ILL. COMP. STAT. ANN. 175/4(b).

222. The State of Illinois and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Illinois.

223. MCOs, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services.

224. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented, or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval, in violation of 740 ILL. COMP. STAT. ANN. 175/3(a)(1)(A).

225. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used, or caused to be made or used, and may still be making, using, or causing to be made or used, false records or statements material to false or fraudulent claims, in violation of 740 ILL. COMP. STAT. ANN. 175/3(a)(1)(B).

226. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used, or caused to be made or used, and may still be making, using, or causing to be made or used, false records or statements material to obligations to pay or transmit money or property to the state or knowingly concealed or knowingly and improperly avoided or decreased or may still be knowingly concealing or knowingly and improperly avoiding or decreasing obligations to pay or transmit money or property to the state, in violation of 740 ILL. COMP. STAT. ANN. 175/3(a)(1)(G).

227. The State of Illinois and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of those claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

228. As a result of Defendants' actions, as set forth above, the State of Illinois and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT X
Violation of the Michigan Medicaid False Claims Act
State of Michigan vs. eviCore

229. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein.

230. This is a civil action brought by Relator in the name of the State of Michigan against Defendant eviCore, under the Michigan Medicaid False Claims Act, MICH. COMP. LAWS ANN. § 400.610a(l).

231. The State of Michigan and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Michigan.

232. MCOs directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services.

233. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made or caused to be made, and may still be making or causing to be made, false statements or false representations of material facts in applications for Medicaid benefits, in violation of MICH. COMP. LAWS ANN. § 400.603(1).

234. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made or cause to be made false statements or false representations of material facts for use in determining rights to Medicaid benefits, in violation of MICH. COMP. LAWS ANN. § 400.603(2).

235. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly concealed or failed to disclose, and may still be concealing or failing to disclose, events affecting their initial or continued rights to receive Medicaid benefits or the initial or continued rights of any other person on whose behalf Defendant has applied for or are receiving benefits for, with intent to obtain benefits to which Defendant or other persons are not entitled or in an amount greater than that to which Defendant or other persons are entitled, in violation of MICH. COMP. LAWS ANN. § 400.603(3).

236. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made or presented or caused to be made or presented, and may still be making or presenting or causing to be made or presented to employees or officers of the State of Michigan, false claims under the social welfare act, Act No. 280 of the Public Acts of 1939, in violation of MICH. COMP. LAWS ANN. § 400.607(1).

237. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made or presented or caused to be made or presented, and may still be making or presenting or causing to be made or presented claims under the social welfare act, Act No. 280 of the Public Acts of 1939, that falsely represent that the goods or services for which the claims were made were medically necessary in accordance with professionally accepted standards, in violation of MICH. COMP. LAWS ANN. § 400.607(2).

238. The State of Michigan, and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

239. As a result of Defendant eviCore's actions, as set forth above, the State of Michigan and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT XI
Violation of New Jersey False Claims Act
State of New Jersey vs. eviCore

240. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein.

241. This is a civil action brought by Relator, in the name of the State of New Jersey, against Defendant eviCore, pursuant to the State of New Jersey False Claims Act, N.J. STAT. ANN. § 2A:32C-5(b).

242. The State of New Jersey and/or one of its agents contracted, directly or indirectly, with one or more carrier contractors in connection with the administration of Medicaid claims and/or claims under other state-funded plans in New Jersey.

243. MCOs directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services.

244. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be causing to be presented, to an employee, officer or agent of the State, or to any contractor, grantee, or other recipient of State funds, false or fraudulent claims for payment or approval under the New Jersey Medicaid program, in violation of N.J. STAT. ANN. § 2A:32C-3(a).

245. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using, or causing to be made or used, false records or statements to get false or fraudulent claims paid or approved by the State, in violation of N.J. STAT. ANN. § 2A:32C-3(b).

246. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using, or causing to be made or used, false records or statements to conceal, avoid or decrease obligations to pay or transmit money or property to the State, in violation of N.J. STAT. ANN. § 2A:32C-3(g).

247. The State of New Jersey and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

248. As a result of Defendants' actions, as set forth above, the State of New Jersey and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT XII
Violation of New York False Claims Act
State of New York vs. eviCore

249. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein.

250. This is a civil action brought by Relator on behalf of the State of New York against Defendant eviCore, under the State of New York False Claims Act, N.Y. STATE FIN. LAW § 190(2).

251. The State of New York and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in New York.

252. MCOs directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services.

253. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval, in violation of N.Y. STATE FIN. LAW § 189(1)(a).

254. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims, in violation of N.Y. STATE FIN. LAW § 189(1)(b).

255. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used, or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to obligations to pay or transmit money or property to the State of New York or one of its political subdivisions, in violation of N.Y. STATE FIN. LAW § 189(1)(g).

256. The State of New York, and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable or necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

257. As a result of Defendants' actions, as set forth above, the State of New York and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT XIII
Violation of Louisiana Medical Assistance Programs Integrity Law
State of Louisiana vs. eviCore

258. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein. The allegations contained in this Count are based upon information and belief.

259. This is a civil action brought by Relator in the name of the State of Louisiana against Defendant eviCore, under the Louisiana Medical Assistance Programs Integrity Law, LA. REV. STAT. ANN. § 46:439.1(A).

260. The State of Louisiana and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Louisiana.

261. MCOs, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services for Louisiana state-funded plan beneficiaries.

262. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval under the Medicaid program, in violation of LA. REV. STAT. ANN. § 46:438.3(A).

263. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims to get such false

or fraudulent claims under the Medicaid program, in violation of LA. REV. STAT. ANN. § 46:438.3(B).

264. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to obligations to pay or transmit money or property to the state, or knowingly concealing or knowingly and improperly avoiding or decreasing obligations to pay or transmit money or property to the state, relative to the Medicaid program, in violation of LA. REV. STAT. ANN. § 46:438.3(C).

265. The State of Louisiana, and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

266. As a result of Defendants' actions, as set forth above, the State of Louisiana and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT XIV
Violation of Montana False Claims Act
State of Montana vs. eviCore

267. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein. The allegations contained in this Count are based upon information and belief.

268. This is a civil action brought by Relator in the name of the State of Montana against Defendant eviCore, under the Montana False Claims Act, MONT. CODE ANN. § 17-8-406.

269. The State of Montana and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Montana.

270. MCOs, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services for Montana state-funded plan beneficiaries.

271. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval under the Medicaid program and/or other state-funded programs, in violation of MONT. CODE ANN. § 17-8-403(1)(a).

272. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims to get such false or fraudulent claims under the Medicaid program and/or other state-funded programs paid for or approved, in violation of MONT. CODE ANN. § 17-8-403(1)(b).

273. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to obligations to pay or transmit money or property to the state, or knowingly concealing or knowingly and improperly avoiding or decreasing

obligations to pay or transmit money or property to the state, relative to the Medicaid program and/or other state-funded programs, in violation of MONT. CODE ANN. § 17-8-403(1)(g).

274. The State of Montana, and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

275. As a result of Defendants' actions, as set forth above, the State of Montana and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT XV
Violation of New Mexico Medicaid False Claims Act
State of New Mexico vs. eviCore

276. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein. The allegations contained in this Count are based upon information and belief.

277. This is a civil action brought by Relator in the name of the State of New Mexico against Defendant eviCore, under the New Mexico Medicaid False Claims Act, N.M. STAT. ANN. § 27-14-7(B).

278. The State of New Mexico and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in New Mexico.

279. MCOs, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services for New Mexico state-funded plan beneficiaries.

280. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval under the Medicaid program and/or other state-funded programs, in violation of N.M. STAT. ANN. § 27-14-4(A).

281. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims to get such false or fraudulent claims under the Medicaid program and/or other state-funded programs paid for or approved, in violation of N.M. STAT. ANN. § 27-14-4(B).

282. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to obligations to pay or transmit money or property to the state, or knowingly concealing or knowingly and improperly avoiding or decreasing obligations to pay or transmit money or property to the state, relative to the Medicaid program and/or other state-funded programs, in violation of N.M. STAT. ANN. § 27-14-4(E).

283. The State of New Mexico, and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

284. As a result of Defendants' actions, as set forth above, the State of New Mexico and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT XVI
Violation of North Carolina False Claims Act
State of North Carolina vs. eviCore

285. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein.

286. This is a civil action brought by Relator on behalf of the State of North Carolina against Defendant eviCore, under the State of North Carolina's False Claims Act, N.C. GEN. STAT. § 1-608(b).

287. The State of North Carolina and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in North Carolina.

288. One or more MCOs, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services.

289. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval under the Medicaid program and/or other state-funded programs, in violation of N.C. GEN. STAT. § 1-607(a)(1).

290. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims to get such false or fraudulent

claims under the Medicaid program and/or other state-funded programs paid for or approved, in violation of N.C. GEN. STAT. § 1-607(a)(2).

291. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to obligations to pay or transmit money or property to the state, or knowingly concealing or knowingly and improperly avoiding or decreasing obligations to pay or transmit money or property to the state, relative to the Medicaid program and/or other state-funded programs, in violation of N.C. GEN. STAT. § 1-607(a)(7).

292. The State of North Carolina and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

293. As a result of Defendants' actions, as set forth above, the State of North Carolina and/or its agencies or political subdivisions have been, and may continue to be, severely damaged

COUNT XVII
Violation of Oklahoma Medicaid False Claims Act
State of Oklahoma vs. eviCore

294. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein. The allegations contained in this Count are based upon information and belief.

295. This is a civil action brought by Relator in the name of the State of Oklahoma against Defendant eviCore, under the Oklahoma Medicaid False Claims Act, OKLA. STAT. ANN. tit. 63, § 5053.2.B.1.

296. The State of Oklahoma and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Oklahoma.

297. MCOs, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services for Oklahoma state-funded plan beneficiaries.

298. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval under the Medicaid program and/or other state-funded programs, in violation of OKLA. STAT. ANN. tit. 63, § 5053.1.B.1.

299. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims to get such false or fraudulent claims under the Medicaid program and/or other state-funded programs paid for or approved, in violation of OKLA. STAT. ANN. tit. 63, § 5053.1.B.2.

300. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to

be made or used, false records or statements material to obligations to pay or transmit money or property to the state, or knowingly concealing or knowingly and improperly avoiding or decreasing obligations to pay or transmit money or property to the state, relative to the Medicaid program and/or other state-funded programs, in violation of OKLA. STAT. ANN. tit. 63, § 5053.1.B.7.

301. The State of Oklahoma, and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

302. As a result of Defendants' actions, as set forth above, the State of Oklahoma and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT XVIII
Violation of Tennessee False Claims Act
State of Tennessee vs. eviCore

303. Relator incorporates herein by reference the preceding paragraphs of this Complaint as though fully set forth herein.

304. This is a civil action brought by Relator, on behalf of the State of Tennessee, against Defendants under Tennessee's False Claims Act, Tenn. Code Ann. §71-5-181, et seq.

305. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval under the Medicaid program, in violation of TENN. CODE ANN. § 71-5-182(a)(l)(A).

306. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims to get such false or fraudulent claims under the Medicaid program paid for or approved, in violation of TENN. CODE ANN. § 71-5-182(a)(l)(B).

307. eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used, or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to obligations to pay or transmit money or property to the state, or knowingly concealing or knowingly and improperly avoiding or decreasing obligations to pay or transmit money or property to the state, relative to the Medicaid program, in violation of TENN. CODE ANN. § 71-5-182(a)(1)(D).

308. The State of Tennessee, or its political subdivisions, unaware of the falsity of the claims and/or statements made, or knowingly caused to be made, by eviCore, and in reliance upon the accuracy of these claims and/or statements, paid, and may continue to pay, for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

309. As a result of Defendants' actions, as set forth above, the State of Tennessee and/or its political subdivisions have been, and may continue to be, severely damaged.

COUNT XIX
Violation of Texas Medicaid Fraud Prevention Act
State of Texas vs. eviCore

310. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein. The allegations contained in this Count are based upon information and belief.

311. This is a civil action brought by Relator in the name of the State of Texas against Defendant eviCore, under the Texas Medicaid Fraud Prevention Act, TEX. HUM. RES. CODE ANN. § 36.101.

312. The State of Texas and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Texas.

313. MCOs, including HCSC, directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services for Texas state-funded plan beneficiaries.

314. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval under the Medicaid program and/or other state-funded programs, in violation of TEX. HUM. RES. CODE ANN. § 36.002(1).

315. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims to get such false

or fraudulent claims under the Medicaid program and/or other state-funded programs paid for or approved, in violation of TEX. HUM. RES. CODE ANN. § 36.002(2).

316. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to obligations to pay or transmit money or property to the state, or knowingly concealing or knowingly and improperly avoiding or decreasing obligations to pay or transmit money or property to the state, relative to the Medicaid program and/or other state-funded programs, in violation of TEX. HUM. RES. CODE ANN. § 36.002(12).

317. The State of Texas, and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

318. As a result of Defendants' actions, as set forth above, the State of Texas and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT XX
Violation of Washington Medicaid Fraud False Claims Act
State of Washington vs. eviCore

319. Relator incorporates herein by reference the preceding paragraphs of the Complaint as though fully set forth herein. The allegations contained in this Count are based upon information and belief.

320. This is a civil action brought by Relator in the name of the State of Washington against Defendant eviCore, under the Washington Medicaid Fraud False Claims Act, WASH. REV. CODE § 74.66.050.

321. The State of Washington and/or one of its agents contracted, directly or indirectly, with one or more MCOs in connection with the administration of Medicaid claims and/or claims under other state-funded plans in Washington.

322. MCOs directly or indirectly, contracted with eviCore in connection with the administration of requests for prior authorization of services for Washington state-funded plan beneficiaries.

323. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, false or fraudulent claims for payment or approval under the Medicaid program and/or other state-funded programs, in violation of WASH. REV. CODE § 74.66.020(1)(a).

324. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims to get such false or fraudulent claims under the Medicaid program and/or other state-funded programs paid for or approved, in violation of WASH. REV. CODE § 74.66.020(1)(b).

325. Defendant eviCore, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used or caused to be made or used, and may still be making, using or causing to

be made or used, false records or statements material to obligations to pay or transmit money or property to the state, or knowingly concealing or knowingly and improperly avoiding or decreasing obligations to pay or transmit money or property to the state, relative to the Medicaid program and/or other state-funded programs, in violation of WASH. REV. CODE § 74.66.020(1)(g).

326. The State of Washington, and/or its agencies or political subdivisions, unaware of the falsity of the claims and/or statements made by Defendant eviCore, and in reliance on the accuracy of these claims and/or statements, paid, and may continue to pay for services that are not medically reasonable and necessary for beneficiaries of health insurance programs funded by the state or its agencies or political subdivisions.

327. As a result of Defendants' actions, as set forth above, the State of Washington and/or its agencies or political subdivisions have been, and may continue to be, severely damaged.

COUNT XXI
Violation of False Claims Act, 31 U.S.C. § 3730(h)
Jane Doe 1 v. eviCore

328. Jane Doe 1 incorporates herein by reference each and every allegation of the preceding paragraphs of this Second Amended Complaint as though fully set forth herein.

329. Jane Doe 1 was engaged in conduct protected under the FCA, including the investigation and reporting of fraud as described herein.

330. eviCore knew that Jane Doe 1 was engaged in such protected conduct.

331. As a result of eviCore's wrongful retaliatory conduct, Jane Doe 1's working conditions become so intolerable that any reasonable person in the employee's position would have felt compelled to resign.

332. eviCore's wrongful retaliatory conduct against Jane Doe 1 was because of Jane Doe 1's involvement in the protected conduct, causing Jane Doe 1 to suffer, and continue to suffer, substantial financial and emotional damage in an amount to be proven at trial.

COUNT XXII
Violation of False Claims Act, 31 U.S.C. § 3730(h)
Jane Doe 2 v. eviCore

333. Jane Doe 2 incorporates herein by reference each and every allegation of the preceding paragraphs of this Second Amended Complaint as though fully set forth herein.

334. Jane Doe 2 was engaged in conduct protected under the FCA, including the investigation and reporting of fraud as described herein.

335. eviCore knew that Jane Doe 2 was engaged in such protected conduct.

336. As a result of eviCore's wrongful retaliatory conduct, Jane Doe 2's working conditions become so intolerable that any reasonable person in the employee's position would have felt compelled to resign.

337. eviCore's wrongful retaliatory conduct against Jane Doe 2 was because of Jane Doe 2's involvement in the protected conduct, causing Jane Doe 2 to suffer, and continue to suffer, substantial financial and emotional damage in an amount to be proven at trial.

PRAYER FOR RELIEF

WHEREFORE, Relators pray that judgment be entered against Defendant, ordering as follows:

A. That Defendant cease and desist from violating 31 U.S.C. § 3729, *et seq*., ALASKA STAT. § 09.58.010, *et seq.*; CAL. GOV'T CODE § 12650, *et seq.*; CONN. GEN. STAT. § 4-277, *et seq.*; FLA. STAT. ANN. § 68.081, *et seq*.; 740 ILL. COMP. STAT. ANN. 175/1, *et seq.*; LA. REV. STAT. ANN. § 46:437.1, *et seq*.; MICH. COMP. LAWS ANN. § 400.601, *et seq.*; MONT. CODE ANN. § 17-8-401, *et seq*.; N.C. GEN. STAT. § 1-605, *et seq.*; N.J. STAT. ANN. § 2A:32C-1, *et seq.*; N.M. STAT. ANN. § 27-14-1, *et seq*.; N.Y. STATE FIN. LAW § 187, *et seq.*; OKLA. STAT. ANN. tit. 63, § 5053, *et seq*.; TENN. CODE ANN. §71-5-182, *et seq.*; TEX. HUM. RES. CODE ANN. § 36.001, *et seq*.; and WASH. REV. CODE § 74.66.005, *et seq*.;

B. That civil penalties of not less than $ 11,665 and up to $23,331 per claim as provided by 31 U.S.C. § 3729(a) and adjusted for inflation be imposed for each and every false or fraudulent claim that Defendant caused to be submitted to the United States and/or its grantees, for each false record or statement Defendant made, used, or caused to be made or used that was material to a false or fraudulent claim, that three times the amount of damages the United States sustained because of Defendants' actions also be imposed;

C. That judgment be entered in Relator's favor and against Defendants in the amount of the damages sustained by the State of Alaska or its political subdivisions multiplied as provided

for in Alaska Stat. § 09.58.010 et seq., plus a civil penalty of not less than $5,500 or more than $11,000 as provided by Alaska Stat. § 09.58.010 et seq., and adjusted for inflation, to the extent such multiplied penalties shall fairly compensate the State of Alaska or its political subdivisions for losses resulting from the various schemes undertaken by Defendants, together with penalties for specific claims to be identified at trial after full discovery and attorney fees and costs as provided by Alaska Stat. § 09.58.010(c).

D. That judgment be entered in Relators' favor and against Defendant in the amount of damages sustained by the State of California multiplied as provided for in CAL. GOV'T CODE § 12650, *et seq.*, plus a civil penalty of not less than $11,463 or more than $23,331 for each act in violation of the State of California's False Claims Act, as provided by CAL. GOV'T CODE § 12650, *et seq.* and adjusted for inflation, to the extent such multiplied penalties shall fairly compensate the State of California for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery.

E. That judgment be entered in Relators' favor and against Defendant in the amount of the damages sustained by the State of Connecticut multiplied as provided for in Conn. Gen. Stat. § 4-275(b)(2), plus a civil penalty of not less than $11,181 or more than $22,363 for each act in violation of the State of Connecticut False Claims Act, as provided by Conn. Gen. Stat. § 4-275(b)(1) and adjusted for inflation, to the extent such multiplied penalties shall fairly compensate the State of Connecticut for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery.

F. That judgment be entered in Relators' favor and against Defendant in the amount of the damages sustained by the State of Florida or its agencies or political subdivisions, multiplied as provided for in FLA. STAT. ANN. § 68.082(2), plus a civil penalty of not less than five thousand

five hundred dollars ($5,500) or more than eleven thousand dollars ($11,000), as provided by FLA. STAT. ANN. § 68.082, to the extent such penalties shall fairly compensate the State of Florida or its agencies or political subdivisions for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

G. That judgment be entered in Relators' favor and against Defendant in the amount of the damages sustained by the State of Illinois or its agencies or political subdivisions, multiplied as provided for in 740 ILL. COMP. STAT. ANN. 175/3(a)(1), plus a civil penalty of not less than $11,181 or more than $22,363, as provided for in 740 ILL. COMP. STAT. ANN. 175/3(a)(1) and adjusted for inflation, and the costs of this civil action as provided by 740 ILL. COMP. STAT. ANN. 175/3(a)(2), to the extent such penalties shall fairly compensate the State of Illinois or its agencies or political subdivisions for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

H. That judgment be entered in Relators' favor and against Defendant in the amount of the damages sustained by the State of Louisiana or its agencies or political subdivisions, plus a fine of not to exceed ten thousand dollars ($10,000) or three times the value of the illegal remuneration, whichever is greater, as provided for in LA. REV. STAT. ANN. § 46:438.6, plus a civil penalty of not less than five thousand five hundred dollars ($5,500) or more than eleven thousand dollars ($11,000) for each act in violation of the Louisiana Medical Assistance Programs Integrity Law, to the extent such penalties shall fairly compensate the State of Louisiana for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

I. That judgment be entered in Relators' favor and against Defendant in the amount of damages sustained by the State of Michigan or its agencies or political subdivisions, for the

value of payments or benefits provided, directly or indirectly, as a result of Defendants' unlawful acts, as provided for in MICH. COMP. LAWS ANN. §§ 400.603 – 400.606, 400.610b, in order to fairly compensate the State of Michigan or its agencies or political subdivisions for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

J. That judgment be entered in Relators' favor and against Defendants in the amount of the damages sustained by the State of Montana or its agencies or political subdivisions, multiplied times three, as provided for in MONT. CODE ANN. § 17-8-403, plus a civil penalty of not less than five thousand five hundred dollars ($5,500) or more than eleven thousand dollars ($11,000) for each act in violation of the Montana False Claims Act, and the attorney fees, expenses, and costs of this civil action as provided by MONT. CODE ANN. § 17-8-403, to the extent such penalties shall fairly compensate the State of Montana for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

K. That judgment be entered in Relators' favor and against Defendants in the amount of the damages sustained by the State of New Jersey or its agencies or political subdivisions, multiplied as provided for in N.J. STAT. ANN. § 2A:32C-3, plus a civil penalty of not less than $11,181 or more than $22,363 as allowed under the federal False Claims Act (31 U.S.C. § 3729 et seq.) for each act in violation, to the extent such penalties shall fairly compensate the State of New Jersey or its agencies or political subdivisions for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

L. That judgment be entered in Relators' favor and against Defendants in the amount of the damages sustained by the State of New Mexico or its agencies or political subdivisions, multiplied times three, as provided for in N.M. STAT. ANN. §§ 27-14-2, 27-14-4, plus a civil penalty of not less than $5,000 and not more than $10,000 for each claim as provided by N.M. STAT. ANN. 44-9-3 , and attorney fees and costs of this civil action as provided by N.M. STAT. ANN. 44-9-1 *et seq*. and N.M. STAT. ANN. 27-14-1 *et seq*., to the extent such penalties shall fairly compensate the State of New Mexico for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

M. That judgment be entered in Relators' favor and against Defendants in the amount of damages sustained by the State of New York or its agencies or political subdivisions, multiplied as provided for in N.Y. STATE FIN. LAW § 189(1)(h), plus a civil penalty of not less than six thousand dollars ($6,000) or more than twelve thousand dollars ($12,000) for each false claim, pursuant to N.Y. STATE FIN. LAW § 189(1)(h), to the extent such penalties shall fairly compensate the State of New York or its agencies or political subdivisions for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

N. That judgment be entered in Relator's favor and against Defendants in the amount of the damages sustained by the State of North Carolina, multiplied as provided for in N.C. Gen. Stat. § 1-605 et seq., plus a civil penalty of not less than $5,500 and not more than $11,000 for each violation as provided by N.C. Gen. Stat. § 1-607, and the costs of this civil action as provided by N.C. Gen. Stat. § 1-607, to the extent such penalties shall fairly compensate the State of North Carolina for losses resulting from the various schemes undertaken by Defendants, together with penalties for specific claims to be identified at trial after full discovery.

O. That judgment be entered in Relators' favor and against Defendants in the amount of the damages sustained by the State of Oklahoma or its agencies or political subdivisions, multiplied times three, as provided for in OKLA. STAT. ANN. tit. 63, § 5053.1, plus a civil penalty of not less than $11,181 or more than $22,363 as provided by OKLA. STAT. ANN. tit. 63, § 5053.1(B) and adjusted for inflation, to the extent such penalties shall fairly compensate the State of Oklahoma for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

P. That judgment be entered in Relator's favor and against Defendants in the amount of the damages sustained by the State of Tennessee, multiplied as provided for in Tenn. Code Ann. § 71-5-181, et seq., plus a civil penalty of not less than $5,000 and not more than $25,000 and adjusted for inflation as provided by Tenn. Code Ann. § 71-5-182, and the costs of this civil action as provided by Tenn. Code Ann. § 71-5-182, to the extent such penalties shall fairly compensate the State of Tennessee for losses resulting from the various schemes undertaken by Defendants, together with penalties for specific claims to be identified at trial after full discovery.

Q. That judgment be entered in Relators' favor and against Defendants in the amount of the damages sustained by the State of Texas or its agencies or political subdivisions, multiplied times two, as provided for in TEX. HUM. RES. CODE ANN. § 36.052, plus a civil penalty of not less than $11,181 or more than $22,363, pursuant to TEX. HUM. RES. CODE ANN. § 36.052(a)(3) and adjusted for inflation, to the extent such penalties shall fairly compensate the State of Texas for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

R. That judgment be entered in Relators' favor and against Defendants in the amount of the damages sustained by the State of Washington or its agencies or political subdivisions,

multiplied times three, as provided for in WASH. REV. CODE § 74.66.020, plus a civil penalty of not less than the greater of $10,957 or the minimum inflation adjusted penalty amount imposed as provided by 31 U.S.C. § 3729(a) and not more than the greater of $21,916 or the maximum inflation adjusted penalty amount imposed as provided by 31 U.S.C. § 3729(a) for each act in violation of the Washington Medicaid Fraud False Claims Act, to the extent such penalties shall fairly compensate the State of Washington for losses resulting from the various schemes undertaken by Defendant, together with penalties for specific claims to be identified at trial after full discovery;

S. That Defendant be enjoined from concealing, removing, encumbering, or disposing of assets which may be required to pay the civil monetary penalties imposed by the Court;

T. That Defendant disgorge all sums by which it has been enriched unjustly by its wrongful conduct;

U. That Relators be awarded the maximum amount allowed pursuant to 31 U.S.C. § 3730(d) and § 3730(h), ALASKA STAT. § 09.58.010, *et seq.*; CAL. GOV'T CODE § 12650, *et seq.*; CONN. GEN. STAT. § 4-277, *et seq.*, FLA. STAT. ANN. § 68.081, *et seq.*, 740 ILL. COMP. STAT. ANN. 175/1, *et seq.*, LA. REV. STAT. ANN. § 46:437.1, *et seq.*, MICH. COMP. LAWS ANN. § 400.601, *et seq*; MONT. CODE ANN. § 17-8-401, *et seq.*; N.C. GEN. STAT. § 1-605, *et seq.*; N.J. STAT. ANN. § 2A:32C-1, *et seq.*, N.M. STAT. ANN. § 27-14-1, *et seq.*, N.Y. STATE FIN. LAW § 187, *et seq.*, OKLA. STAT. ANN. tit. 63, § 5053, *et seq.*; TENN. CODE ANN. §71-5-182, *et seq.*; TEX. HUM. RES. CODE ANN. § 36.001, *et seq*; and WASH. REV. CODE § 74.66.005, *et seq.*;

V. That Defendant reinstate Jane Doe 1 and Jane Doe 2 to the same positions that they would have had but for the wrongful constructive termination;

W. That Jane Doe 1 and Jane Doe 2 be awarded two times the amount of back pay they would have earned but for the retaliation, and interest on that award;

X. That Jane Doe 1 and Jane Doe 2 be awarded compensation for all special damages they have sustained as a result of eviCore's termination in violation of public policy.

Y. That Relators be awarded all costs, including but not limited to, court costs, expert fees and all attorney fees, costs and expenses incurred by Relators in the prosecution of this suit; and

Z. That Relators be granted such other and further relief as the Court deems just and proper.

JURY TRIAL DEMAND

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, SW Challenger, Jane Doe 1, and Jane Doe 2 demand a trial by jury of all issues so triable.

DATED: September 23, 2020

Respectfully submitted,

SEEGER WEISS LLP

By: */s/ Stephen A. Weiss*

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Counsel for Plaintiffs SW Challenger, LLC, Jane Doe 1, and Jane Doe 2

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA *ex rel.* SW CHALLENGER, LLC,

Plaintiffs,

- against -

EVICORE HEALTHCARE MSI, LLC,

Defendant.

19 Civ. 2501 (VM)

ORDER

VICTOR MARRERO, United States District Judge.

On January 28, 2021, the defendant in the above-captioned matter filed an unopposed letter request to unseal the Complaint and "any notice of declination filed by the U.S. Attorney's Office." (See Dkt. No. 32.) The Court hereby **GRANTS** the request.

The Clerk of Court is directed to unseal the Complaint in the above-captioned case (see Dkt. No. 1), and enter the attached declination letter into the public docket.

SO ORDERED.

Dated: New York, New York
8 February 2021

Victor Marrero
U.S.D.J.

U.S. Department of Justice

United States Attorney
Southern District of New York

86 Chambers Street, 3rd floor
New York, New York 10007

January 21, 2020

UNDER SEAL

BY HAND
Honorable Victor Marrero
United States District Court Judge
United States District Court
Southern District of New York
500 Pearl Street, Suite 1040
New York, New York 10007

Re: *United States of America* et al. ex rel. *SW Challenger, LLC, v. Evicore Healthcare MSI, LLC* et al., 19 Civ. 2501 (VM) (Under Seal)

Dear Judge Marrero:

This Office represents the United States (the "Government") in the above-referenced *qui tam* action filed pursuant to the False Claims Act, 31 U.S.C. § 3729 *et seq.*, as amended. The United States and the State Plaintiffs[1] have decided not to intervene in this action. Enclosed please find a signed original of the Notice of Election to Decline Intervention, as well as a proposed Order in connection with this Notice. The Government is filing this notice of declination on behalf of the States with their consent. We respectfully request that the Court sign the proposed Order and send both the Government's Notice and the Order to the Clerk for filing.

In the event the Court approves the proposed Order, we respectfully request that the Court provide this Office with a copy, and we have enclosed a self-addressed envelope for that purpose. We will then serve a copy of the signed Order on the State Plaintiffs and counsel for the relator.

[1] Relator has also named as plaintiffs in this action the states of Alaska, Connecticut, Florida, Illinois, Louisiana, Michigan, Montana, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Tennessee, Texas, and Washington.

Thank you for your consideration of this request.

Respectfully,

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

By: _____
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Encls.

cc: BY EMAIL

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA; and
the STATE OF ALASKA,
the STATE OF CONNECTICUT,
the STATE OF FLORIDA,
the STATE OF ILLINOIS,
the STATE OF LOUISIANA,
the STATE OF MICHIGAN,
the STATE OF MONTANA,
the STATE OF NEW JERSEY,
the STATE OF NEW MEXICO,
the STATE OF NEW YORK,
the STATE OF OKLAHOMA,
the STATE OF TENNESSEE,
the STATE OF TEXAS, and
the STATE OF WASHINGTON

ex. rel. SW CHALLENGER, LLC,

Plaintiffs,

v.

EVICORE HEALTHCARE MSI, LLC, and
WELLCARE HEALTH PLANS, INC.;

Defendants.

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19 Civ. 2501 (VM)
UNDER SEAL

NOTICE OF ELECTION TO DECLINE INTERVENTION

Pursuant to the False Claims Act, 31 U.S.C. § 3730(b)(4)(B), the United States and the States named as plaintiffs[1] in the above-captioned action hereby notify the Court of their decision not to intervene in this action.

Although the United States decline to intervene, we respectfully refer the Court to 31 U.S.C. § 3730(b)(1), which allows the relator to maintain the action in the name of the United States; providing, however, that the "action may be dismissed only if the court and the Attorney General give written consent to the dismissal and their reasons for consenting." *Id.* Therefore, the United States and the States requests that, should the relator or the defendant propose that this action be dismissed, settled, or otherwise discontinued, the moving party (or parties) be required to solicit the written consent of the United States and the States before applying for Court approval.

Furthermore, pursuant to 31 U.S.C. § 3730(c)(3), the United States requests that all pleadings and briefs filed in this action be served upon the United States. The United States also requests that the Court direct relator's counsel to serve on the United States any orders issued by the Court. The United States reserves its right to order any deposition transcripts, to intervene in this action, for good cause, at a later date, and to seek the dismissal of the relator's action or claims under 31 U.S.C. § 3730(e)(4).

1 Relator has named as plaintiffs in this action the states of Alaska, Connecticut, Florida, Illinois, Louisiana, Michigan, Montana, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Tennessee, Texas, and Washington.

The United States also requests that it be served with all notices of appeal.

The States pursuant to their respective False Claims Acts or analogous state statutes: (1) reserve their right to intervene at a later date upon a showing of good cause, *see, e.g.*, N.Y. State Fin. Law § 190(5)(a); (2) request that all pleadings filed in this action be served upon the States, *see, e.g.*, N.Y. State Fin. Law § 190(2)(f); (3) request that the Court direct the relator's counsel to serve upon the States any orders issued by the Court, *see, e.g.*, N.Y. State Fin. Law § 190(2)(f); (4) reserve their right to order any deposition transcripts in this case; and (5) request that if the relator or the defendants propose that any claims be dismissed, settled, or otherwise discontinued, the Court require that such litigant(s) solicit the written the consent of the States before applying for Court approval, *see, e.g.*, N.Y. State Fin. Law § 190(5)(a).

Dated: New York, New York
January 21, 2020

Respectfully submitted,

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

By: _____
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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA; and the STATE OF ALASKA, the STATE OF CONNECTICUT, the STATE OF FLORIDA, the STATE OF ILLINOIS, the STATE OF LOUISIANA, the STATE OF MICHIGAN, the STATE OF MONTANA, the STATE OF NEW JERSEY, the STATE OF NEW MEXICO, the STATE OF NEW YORK, the STATE OF OKLAHOMA, the STATE OF TENNESSEE, the STATE OF TEXAS, and the STATE OF WASHINGTON *ex. rel.* SW CHALLENGER, LLC, Plaintiffs, v. EVICORE HEALTHCARE MSI, LLC, and WELLCARE HEALTH PLANS, INC.; Defendants.	19 Civ. 2501 (VM) **UNDER SEAL**

ORDER

The United States of America (the "Government"), by its attorney, Geoffrey S. Berman, having now declined to intervene pursuant to the False Claims Act, 31 U.S.C. § 3730(b)(4)(B), with respect to the claims raised in the Complaint filed by the relator in the above-captioned

action; and the States which are named as co-plaintiffs in this action (the "States") having also declined to intervene pursuant to their respective false claims acts or analogous statutes with respect to the claims raised in the above-captioned *qui tam* action;

IT IS ORDERED THAT:

1. The Complaint shall be unsealed thirty days after entry of this Order; and, in the event that relator has not moved to dismiss this action, service upon defendants by the relator is authorized as of that date. If the relator voluntarily dismisses the complaint pursuant to Rule 41(a)(1) of the Federal Rules of Civil Procedure within this thirty-day period, the relator may seek to modify this Order with the consent of the United States and the States or by motion on notice to the United States and the States.

2. The Notice of Election to Decline Intervention shall be served by the relator upon defendants only after service of the complaint.

3. Except for the Complaint, this Order and the Notice of Election to Decline Intervention, all other contents of the Court's file in this action as of the date of this Order shall remain under seal and not be made public or served upon the defendants.

3. Upon the unsealing of the Complaint, the seal shall be lifted as to all matters occurring in this action subsequent to the date of this Order.

4. The parties shall serve all pleadings and motions filed in this matter, including supporting memoranda, upon the Government and the States. The Government and the States may order any transcripts of depositions. The Government and the States may seek to intervene with respect to the allegations in the relator's Complaint, for good cause, at any time, or to seek dismissal of this action.

5. All further orders of this Court in this matter shall be sent to the Government and the States by relator.

6. Should the relator or the defendants propose that the Complaint or any of its allegations be dismissed, settled, or otherwise discontinued, or that a defendant be dismissed from the case, the moving party (or parties) must solicit the written consent of the Government and the States before applying for Court approval.

Dated: _____, 2020

SO ORDERED:

_____
HONORABLE VICTOR MARRERO
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA *ex rel.* SW CHALLENGER, LLC, et al., Plaintiffs, - against - EVICORE HEALTHCARE MSI, LLC, Defendant.	19 Civ. 2501 (VM) **DECISION AND ORDER**

VICTOR MARRERO, United States District Judge

Plaintiff relator, SW Challenger, LLC, on behalf of the United States and the states of Alaska, California, Connecticut, Florida, Illinois, Louisiana, Michigan, Montana, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Tennessee, Texas, and Washington (the "Qui Tam States"), and Jane Doe 1 and Jane Doe 2 (together with the forgoing entities, "Relators"), filed the second amended complaint in this action on September 23, 2020. (See "SAC," Dkt. No. 15.) The SAC brings twenty-two causes of action against eviCore Healthcare MSI, LLC ("eviCore") alleging healthcare fraud in violation of the False Claims Act ("FCA"), 31 U.S.C. §§ 3729, et seq., and various analogous state laws.

Now before the Court is eviCore's motion to dismiss the SAC. (See "Motion," Dkt. No. 21.) For the reasons set forth below, the Motion is GRANTED.

I. BACKGROUND

A. FACTS[1]

This qui tam[2] action arises from eviCore's alleged practice, beginning as early November 2016, of automatically approving medical services without undertaking the proper review. According to Relators, eviCore contracted with health-insurance companies covering certain Medicare and Medicaid beneficiaries to provide prior authorization and utilization management services that it did not actually provide. Relators also allege that eviCore retaliated against two employees, Jane Doe 1 and Jane Doe 2, by taking adverse action against them when they refused to engage in the alleged fraudulent scheme.

Relators allege that they have "direct personal knowledge" of eviCore's auto-approval of physical therapy treatment. (SAC ¶ 24.) With respect to eviCore's other alleged

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[1] Except as otherwise noted, the following background derives from the SAC. The Court takes all facts alleged therein as true and construes the justifiable inferences arising therefrom in the light most favorable to Plaintiff, as required under the standard set forth in Section II, infra. See Spool v. World Child Int'l Adoption Agency, 520 F.3d 178, 180 (2d Cir. 2008) (citing GICC Cap. Corp. v. Tech. Fin. Grp., Inc., 67 F.3d 463, 465 (2d Cir. 1995)); see also Chambers v. Time Warner, Inc., 282 F.3d 147, 152 (2d Cir. 2002). Except when specifically quoted, no further citation will be made to the SAC.

[2] Under the qui tam provisions of the FCA, private persons "may bring a civil action for a violation of section 3729 for the person and for the United States Government." 31 U.S.C. § 3730(b)(1). Such suits are brought "in the name of the Government," and the plaintiffs bringing such suits are called "relators." United States ex rel. Woods v. Empire Blue Cross and Blue Shield, No. 99 Civ. 4968, 2002 WL 1905899, at *4 (S.D.N.Y. 2002) (citing 31 U.S.C. § 3730(b)(2)).

auto-approval processes, Relators acknowledge that they do not have firsthand knowledge, but assert that "through their interactions with other reviewers working at eviCore, they learned that these procedures were not limited to physical therapy." (Id.)

1. Program Structure

Relators allege fraud with respect to two programs: Medicare Advantage and Medicaid. The federal Medicare program provides healthcare benefits to elderly and disabled people, while Medicaid, a joint federal and state program, provides healthcare benefits to indigent and disabled people.[3] The Centers for Medicare and Medicaid Services ("CMS") is the federal agency that administers both the Medicare and Medicaid programs. CMS does not itself provide healthcare to qualifying individuals. Instead, CMS contracts with private health-insurance companies (known as managed care organizations ("MCOs")), that in turn approve and distribute funds for healthcare services to providers, such as hospitals, nursing facilities, rehabilitation facilities, and home health agencies. Those providers then deliver the care directly to program beneficiaries.

When a medical service is approved, the patient receives

[3] Medicare is set forth in subchapter XVIII of the Social Security Act. 42 U.S.C. § 1395c. Medicaid is set forth in subchapter XIX of that Act. Id. §§ 1396-1, 1396a.

the service from the provider, and the provider then submits the bill to the payor, and the payor pays for the service. In the case of Medicare Advantage and Medicaid Plans, the ultimate payor is the Government. Under Medicare Part C, or "Medicare Advantage," CMS pays MCOs an amount calculated based on the number of beneficiaries enrolled, rather than the number or cost of services provided. This amount is adjusted based on the beneficiaries' health status and other factors. As a joint program, Medicaid is funded by both the federal government and the states. The federal portion is known as the Federal Medical Assistance Percentage ("FMAP"). FMAP is calculated based on a state's per capita income as compared to the national average, and, like Medicare Advantage, is not reimbursed on a per-service basis.

2. EviCore's Role

EviCore is not an MCO. Rather, eviCore contracts with MCOs to provide utilization management and prior authorization services. "Utilization management" and "prior authorization" are terms of art in the healthcare industry that describe the review of claims for payment and the provision of reimbursement determinations for services ordered by doctors and other health professionals. The SAC does not define these terms but broadly alleges that by contracting to provide utilization management and prior

authorization, eviCore agreed to review requests submitted by doctors and other providers to determine whether the proposed medical procedures were covered under the plans.

Whether a procedure is covered depends on a particular MCO's internal rules, which in turn are subject to federal, and in some cases state, law. Relators have not identified any specific MCO contracts at issue here that governed eviCore's utilization management or prior authorization services. Instead, Relators assert that, by contracting with MCOs to provide these "core" functions in the administration of Medicare Advantage and Medicaid plans, "eviCore has agreed to comply with all applicable Medicare and Medicaid laws, regulations, and CMS instructions." (SAC ¶ 11.)

Under these guidelines, according to Relators, requests for payment for Medicare Advantage beneficiaries should be approved only when the requested services are "reasonable and necessary." (SAC ¶ 66.) For Medicaid, Relators acknowledge that "medical necessity" is not explicitly defined in the Medicaid Act, but the law does require states to maintain procedures to safeguard against unnecessary utilization and empowers states to limit reimbursable services based on criteria such as "medical necessity."

3. EviCore's Alleged Auto-Approval Scheme

In instances involving eviCore, when a physician or

other provider determines that a Medicare Advantage or Medicaid beneficiary requires a medical service for which prior authorization is required, the provider submits a request to eviCore. When a request is submitted, eviCore enters the information into one of two request management systems -- either "Image One" or "ISAAC" -- depending on the type of request. (SAC ¶ 89.) From there, the SAC's allegations regarding the typical practice are sparse. What is clear, however, is that some combination of human and machine review follows.

The humans involved in the process are healthcare professionals, called clinical reviewers, who are trained in the application of utilization review criteria and MCO rules. EviCore also uses, seemingly among other automation tools, a data analytics system, called CorePath, to automate prior authorization requests. Relators allege that, for each request, clinical reviewers are supposed determine whether the service is medically necessary before prior authorization will be approved. If after review there is insufficient information for clinical reviewers to make a determination, they are supposed to request the necessary additional documentation and place the case on hold pending investigation. Instead, however, Relators allege that the clinical reviewers do not review these automated

determinations because of "a variety of interlocking schemes" to ensure fast, low-cost review. (SAC ¶ 98.)

These "schemes" were designed, according to Relators, because MCOs' contracts with eviCore include a timing provision, requiring eviCore to review each request for prior authorization quickly, in many cases, within 24 to 48 hours. Failure to meet these timelines results in monetary penalties. Relators allege that eviCore did not hire enough staff to properly service its MCO subcontracts and meet these deadlines. Thus, Relators allege, "for certain cases eviCore created a swinging gate prior authorization approval process that approved anything and everything that passed before it," and in those instances, eviCore "provided worthless services in exchange for its contractual payment." (SAC ¶ 21.)

a. CorePath

Relators allege that the CorePath data analytics system involves automation that is "not based on valid and reliable clinical information and evidenced-based clinical guidelines, but rather on criteria that do not meaningfully determine the proper need and scope for services, such as the number of visits at issue." (SAC ¶ 91.) To support this allegation, Relators cite a handful of documents indicating not that CorePath was designed to auto-approve all requests, but that its goal was to allow eviCore to handle a high volume of

requests efficiently.

For example, the SAC references a September 14, 2017 phone call in which eviCore's musculoskeletal product advisor indicated that eviCore's expansion would increase the number of requests, and it would be impossible for clinical reviewers to keep pace with the increased volume. Thus, this advisor worked on developing CorePath artificial intelligence for pediatric occupational and physical therapy, which would automatically approve the first and second such requests from a provider without clinical review. Similarly, an internal eviCore email dated October 26, 2017 described the CorePath system as requiring providers to respond to a "limited set of clinical question[s]" as part of their requests. (SAC ¶ 117.) The email described CorePath's "primary intention" as being "to resolve a high majority of episodes of care without requiring any practitioner review." (Id.) Likewise, in a September 15, 2018 phone call, eviCore Vice President for Clinical Content and Integration stated that the automated process was intended to make eviCore's utilization review scalable. Relators further allege that minutes from a July 23, 2019 meeting indicate that, during a time of high queue volume, senior leadership at eviCore adjusted CorePath to include auto-approvals of every second request for visits.

According to Relators, CorePath's automation processes

have allegedly been used at eviCore since March 2019 for certain providers across several states including at least Arkansas, Connecticut, Illinois, Kentucky, Louisiana, Maine, Missouri, Mississippi, New Mexico, New York, North Carolina, Oklahoma, South Carolina, Tennessee, and Texas.

b. Image One

Relators allege that eviCore's Image One software also restricts clinical reviewers from meaningfully examining requests. In particular, Relators allege that Image One makes it impossible to deny certain categories of requests. As an example, Relators allege that on September 6, 2017, the manager of Musculoskeletal Specialized Therapy indicated that she had found a logic problem in the Image One system, by which certain cases were subject to an auto-approval directive but the Image One system did not prevent adverse determinations. The same manager indicated in a March 7, 2018 email that an IT update was required because the system prohibited denials.

c. Auto-Approval Directives

Relators also allege that eviCore directed its clinical reviewers to auto-approve services requested in certain jurisdictions, among certain populations, for certain categories of services, or under certain healthcare plans. To support this allegation, Relators cite an October 27, 2017

email in which eviCore's Senior Vice President of Program Operations and its Chief Medical Director directed that Blue Cross Blue Shield Texas requests for pediatric treatment be auto-approved. At that time, Blue Cross Blue Shield Texas expected full medical-necessity review. Relators allege that at a meeting approximately one month after this email, however, an eviCore provider-relationships representative and Vice President at Blue Cross Blue Shield Texas *agreed* that pediatric developmental requests would be auto-approved for a six-month period to satisfy certain providers and mitigate complaints. According to Relators, eviCore never reimplemented full medical-necessity review after that six-month period.

Relators also cite two internal eviCore documents with the words "auto-approval" in the titles. One document, titled "Auto-Approvals (IO-CDP) 6-1-20," states "[a]pprovals by QPID-sPA-PI-UPADS are not health plan directed approvals. These are approvals based on survey responses and other data collected by the system." (SAC ¶ 105.) Relators allege that this same notation is located in another internal eviCore document titled "Auto Approvals (ISAAC) 5-11-20." (Id.)

An October 28, 2017 email from the manager of Musculoskeletal Specialized Therapy noted: "[A]ny Passport cases with a start date of 11/1/17 or later requires medical

necessity review. A start date of 10/31/17 or before remains auto approval." (Id. ¶ 109.) The following month, on November 8, 2017, the same manager described cases in which clinical reviewers were "auto approving . . . significantly more visits than we would approve." (Id. ¶ 111.) She subsequently requested egregious examples of such auto-approvals to use at an upcoming meeting and cited a case in which 200 visits for an ankle sprain had been approved.

Relators allege that over Labor Day Weekend in 2018, eviCore established a protocol to approve the first three requests for any course of care, and this protocol continued for 126 days while request volumes were high.

d. Additional Evidence

Relators allege that on March 23, 2018, the manager of Musculoskeletal Specialized Therapy directed pediatric physical therapy clinical reviewers to review occupational-therapy requests. According to Relators, staffing clinical reviewers to cases outside their expertise occurs because of the auto-approval scheme, in which requests are approved regardless of need. The SAC alleges that one medical reviewer, Jaimie Clodfelter, was regularly asked to approve or review surgical requests, despite the fact that she is not a surgeon and does not have the experience necessary to meaningfully review these requests.

As further evidence of the scheme, Relators allege that eviCore began to remove or obscure references to automatic approval beginning in early February 2019. However, eviCore maintained its auto-approval practices under different titles. Relators point to an October 3, 2019 WebEx meeting for a Texas Fair Hearing in which an eviCore employee allegedly misrepresented that an approval was based on a medical-necessity review. In a later telephone conversation, this employee allegedly asked one of the Relators to "help her craft a plausible medical necessity explanation for the auto-approval review decision." (SAC ¶ 128.)

Relators allege that the majority of services that resulted from eviCore's scheme were approved for payment, performed, and reimbursed, even though none of the requests had been properly reviewed for medical necessity. Thus, according to Relators, eviCore received millions of dollars to perform services which either never happened or were undertaken in a worthless fashion. Relators allege that the scheme cost CMS, the Qui Tam States and its MCOs significant amounts of money, and in some cases created the risk of patient harm.

4. EviCore's Alleged Retaliation

Relators further allege that Jane Doe 1 and Jane Doe 2 tried to reform eviCore's auto-approval processes and were

retaliated against as a result. Jane Doe 1 was a clinical reviewer who was assigned to improve certain of eviCore's pediatric guidelines. Relators contend that because of her work, Jane Doe 1 was familiar with the authorization process at eviCore. The SAC alleges that Jane Doe 1 learned about the compliance whitewashing and auto-approvals while working on a project to update clinical review job aids and certain administrative algorithms between January 2018 and January 2020.

Jane Doe 1 emailed eviCore's Compliance Department on February 8, 2019, reporting her concerns with eviCore's auto-approval processes. On February 22, 2019, the Compliance Department directed the removal of "auto-approval" language from job aids but did not change the review process. The following month, Jane Doe 1 participated in meetings on March 13 and 15, 2019 between eviCore and WellCare senior management in which she voiced her concerns. According to Relators, shortly thereafter, her manager informed Jane Doe 1 that she was not permitted to accept meeting requests without first checking with her direct manager. Then, in May 2019, Jane Doe 1's role was limited to reviewing prior authorizations. Lastly, during the COVID-19 pandemic, a notice was sent to all employees stating that they were not expected to reach prior productivity levels; however, Jane Doe 1 allegedly

received a verbal warning from her manager that she needed to meet her productivity requirements. The SAC alleges that because of this, Jane Doe 1 was "forced" to resign in March 2020. (SAC ¶ 150.)

Jane Doe 2 was also a clinical reviewer at eviCore. In mid-September 2017, Jane Doe 1 and Jane Doe 2 worked together to develop a pediatric pathway for CorePath. On September 15, 2017, Jane Doe 2 expressed her concerns to eviCore Vice President for Clinical Content and Integration about whether the system could make the same evidence-based review decisions a clinical reviewer would in light of the complexity of pediatric decisions. The SAC alleges that Jane Doe 2 was removed from meetings with the team thereafter.

In September 2019, Jane Doe 2 notified an audit manager and the Manager of Clinical Review that a particular decision required additional information. On a December 27, 2019 phone call, Jane Doe 2 was reprimanded by her manager and eviCore's director of therapy for "directing care." (Id. ¶ 157.) After the call, Jane Doe 2 was removed from certain teams.

On March 29, 2020, Jane Doe 2 again reported concerns about eviCore's auto-approval processes to the Compliance Department. Jane Doe 2 also received an email during the COVID-19 pandemic that reprimanded her regarding her low productivity despite a company-wide reduction in productivity

expectations. The SAC alleges that Jane Doe 2, like Jane Doe 1, was "forced" to quit. (SAC ¶ 163.)

B. PROCEDURAL HISTORY

The initial complaint in this action was filed under seal on March 20, 2019. (Dkt. No. 36.) The case remained under seal while the federal government and the Qui Tam States determined whether to intervene. See 31 U.S.C. § 3730(b)(2), (3). On January 21, 2020, the Government filed a declination notice on its own behalf and on behalf of the Qui Tam States, indicating that neither it nor the Qui Tam States intended to intervene in the action. (See Dkt. No. 35.) On May 21, 2020, Relators filed the first amended complaint under seal. (Dkt. No. 7.) The Court ordered the case unsealed in June 2020, and Relators moved to further amend the complaint on September 22, 2020. (Dkt. No. 11.) The Court granted the motion, and Relators filed the SAC on September 23, 2020. (Dkt. No. 15.)

The SAC charges eviCore with presenting a false claim, in violation of 31 U.S.C. § 3729(a)(1)(A) ("Count One"); making or using a false record or statement material to a false claim, in violation of id. § 3729(a)(1)(B) ("Count Two"); making or using a false record to avoid an obligation to pay the federal government (i.e., a "reverse false claim"), in violation of id. § 3729(a)(1)(G) ("Count Three"); conspiring to violate the FCA, in violation of id.

§ 3729(a)(1)(C) ("Count Four"); violations of analogous state laws ("Counts Five through Twenty"); and two retaliation counts for the alleged constructive discharges of Jane Doe 1 and Jane Doe 2 in violation of id. § 3730(h) ("Counts Twenty-One through Twenty-Two").

The parties exchanged premotion letters pursuant to the Court's Individual Practices on November 12, 19, and 20, 2020. (Dkt. Nos. 17-19.) Defendant eviCore then moved to dismiss the SAC on November 23, 2020. (See Motion.) EviCore also filed a memorandum of law in support of the Motion. ("EviCore's Br.," Dkt. No. 22.) Relators opposed the Motion on January 22, 2021. ("Relators' Br.," Dkt. No. 31.) While the United States and the Qui Tam States declined to intervene in the action, the Government submitted a statement of interest on March 1, 2021 to clarify certain issues relevant to resolving the Motion. (See "SOI," Dkt. No. 39.) EviCore filed its reply memorandum of law in further support of the Motion on April 12, 2021. ("Reply," Dkt. No. 42.)

C. THE PARTIES' ARGUMENTS

EviCore argues that Count One must be dismissed because the SAC "does not identify any specific false claims" approved by eviCore or any false claims that an MCO submitted to CMS because of an eviCore approval. (EviCore's Br. at 10-11.) Similarly, because MCOs do not submit "claims" to CMS for

eviCore-approved services, the SAC fails to allege that eviCore "caused MCOs to submit false claims to the government." (Id. at 11.) These pleading deficiencies, according to eviCore, also render the SAC fatally flawed under Federal Rule of Civil Procedure ("Rule") 9(b). EviCore additionally contends that under Rule 9(b), Relators are required to plead the FCA violations with specificity, but instead, Relators never identify a single service that eviCore erroneously approved, a claim for such service submitted to CMS, who submitted such claim when, or what payment MCO sought from CMS in connection with the allegedly false claim. Similarly, eviCore contends that the SAC does not identify any statute or contract term that eviCore allegedly violated. EviCore further argues that Relators failed to plausibly allege that, under Second Circuit precedent, the services eviCore provided were "worthless." (Id. at 15-16.)

EviCore contends that Count Two should be dismissed because Relators failed to identify any material, knowingly false statements made by eviCore. Count Three should be dismissed, according to eviCore, for the same reasons and because Relators have not alleged that eviCore avoided paying money owed to the Government. On Count Four, eviCore argues that Relators have failed to establish a conspiracy because the SAC does not identify anyone outside eviCore with whom

eviCore allegedly conspired. EviCore insists that the various state-law claims in Counts Five through Twenty must also fail for the same reasons as the federal claims. EviCore argues that the retaliation claims in Counts Twenty-One through Twenty-Two must be dismissed because Relators have failed to plausibly allege adverse action on eviCore's part or constructive discharge. EviCore additionally argues that the statute of limitations bars claims made before May 2014 because eviCore has no means of determining whether the SAC relates back to the initial complaint under Rule 15.

In response, Relators argue that they need not allege any false claims made directly to the Government and can instead rely on allegations of false claims made to MCOs, who receive and distribute federal funds. Relators insist that allegations of specific auto-approval protocols satisfy Rule 9(b) because they "lead to a strong inference that specific claims were indeed submitted." (Relators' Br. at 6 (quoting United States ex rel. Chorches for Bankr. Est. of Fabula v. Am. Med. Response, Inc., 865 F.3d 71, 86 (2d Cir. 2017)).) Relators challenge eviCore's argument that no specific breaches of either statutes or contracts are alleged, and they point out that they have sufficiently pleaded that eviCore entered contracts with MCOs. Relators further argue that the services eviCore provided were "worthless" under

Second Circuit precedent. Relators adequately pleaded knowledge, they insist, by alleging a noncompliant auto-approval scheme and eviCore's efforts to "whitewash this fraud." (Id. at 13.) The allegations of motive and opportunity, according to Relators, also meet the pleading requirements for scienter. Relators argue that the SAC plausibly alleges false statements by generally outlining the fraudulent scheme.

On Count Three, Relators argue that the SAC adequately pleads "reverse false claims" by alleging that eviCore decided to "retain, rather than return," funds it was paid for services it did not provide. (Id. at 16.) Relators argue that the state-law claims in Counts Five through Twenty are not identical to the federal claims, and point specifically to the Texas false claims statute, which Relators characterize as broader than the FCA. Relators contend that the remaining state-law claims have been plausibly alleged because the SAC makes out a "nationwide fraudulent scheme." (Id. at 20.) Regarding the SAC's retaliation claims, Relators contend that the allegations are sufficient, and no more specificity or detail is required.[4] Relators further argue that the statute of limitations does not bar claims after March 2013 -- not May 2014 -- because the SAC relates back to

[4] Relators do not address eviCore's arguments urging dismissal of the conspiracy charged in Count Four.

the initial complaint.

While the Government declined to intervene in the action, it nevertheless submitted a statement of interest, arguing that claims made to contractors are "encompassed within the meaning of 'claim' under the FCA," and that it is not fatal that the submission of the allegedly false claims were not made directly to the Government. (SOI at 7.) The Government additionally clarifies that the approval of medically unnecessary treatment could give rise to false claims by causing the provider to bill for unnecessary treatment, billing for review services that were not provided, or indirectly affecting CMS's calculation of capitation rates.

II. LEGAL STANDARD

A. RULE 12(b)(6)

"To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" Ashcroft v. Iqbal, 556 U.S. 662, 678 (2009) (quoting Bell Atl. Corp. v. Twombly, 550 U.S. 544, 570 (2007)). This standard is met "when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." Id. A complaint should be dismissed if the plaintiff has not offered factual allegations sufficient to render the claims facially

plausible. See id. However, a court should not dismiss a complaint for failure to state a claim if the factual allegations sufficiently "raise a right to relief about the speculative level." Twombly, 550 U.S. at 555.

In resolving a motion to dismiss, the Court's task is "to assess the legal feasibility of the complaint, not to assay the weight of the evidence which might be offered in support thereof." In re Initial Pub. Offering Sec. Litig., 383 F. Supp. 2d 566, 574 (S.D.N.Y. 2005) (internal quotation marks omitted), aff'd sub nom. Tenney v. Credit Suisse First Bos. Corp., No. 05 Civ. 3430, 2006 WL 1423785 (2d Cir. May 19, 2006). In this context, the Court must draw reasonable inferences in favor of the nonmoving party. See Chambers v. TimeWarner, Inc., 282 F.3d 147, 152 (2d Cir. 2002). However, the requirement that a court accept the factual allegations in the complaint as true does not extend to legal conclusions. See Iqbal, 556 U.S. at 678.

B. RULE 9(b)

"Qui tam complaints filed under the FCA, because they are claims of fraud, are subject to Rule 9(b)." Chorches, 865 F.3d at 81. Rule 9(b) requires that "[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake." Fed. R. Civ. P. 9(b). To satisfy this Rule, a complaint alleging fraud must

"(1) specify the statements that the plaintiff contends were fraudulent, (2) identify the speaker, (3) state where and when the statements were made, and (4) explain why the statements were fraudulent." United States ex rel. Ladas v. Exelis, Inc., 824 F.3d 16, 25 (2d Cir. 2016) (citation omitted).

"Underlying schemes and other wrongful activities that result in the submission of fraudulent claims are included in the 'circumstances constituting fraud or mistake' that must be pled with particularity pursuant to Rule 9(b)." United States ex rel. Polansky v. Pfizer, Inc., No. 04 Civ. 0704, 2009 WL 1456582, at *5 (E.D.N.Y. May 22, 2009) (citation omitted).

"Rule 9(b) also applies to claims brought under state analogues of the FCA in federal court." United States v. Lab'y Corp. of Am. Holdings, No. 107 Civ. 05696, 2015 WL 7292774, at *3 (S.D.N.Y. Nov. 17, 2015) (citations omitted). However, retaliation claims are not subject to Rule 9(b). See Chorches, 865 F.3d at 95 ("The particularity requirement of Rule 9(b) does not apply to retaliation claims under the FCA." (citations omitted)).

III. DISCUSSION

As an initial matter, the Court is unpersuaded by eviCore's argument in a footnote that the Court lacks

jurisdiction over this action under Section 3730(e)(4) of the FCA. (See EviCore's Br. at 3 n.4.) Section 3730(e)(4)(A) provides that claims under this section shall be dismissed "if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed . . . unless. . . the person bringing the action is an original source of the information." 31 U.S.C. § 3730(e)(4)(A). The SAC alleges that Relators are indeed the "original source" of the allegations in the SAC. SAC ¶ 42; see J.S. ex rel. N.S. v. Attica Cent. Sch., 386 F.3d 107, 110 (2d Cir. 2004) (explaining that when deciding motions to dismiss for lack of subject-matter jurisdiction, courts "must accept as true all material factual allegations in the complaint"). Moreover, eviCore has not established that the "public disclosures" it cites are the "basis" of the claims here. While the action against eviCore's predecessor CareCore may have thematic overlap with this one (see SAC ¶ 53), the claims here relate to eviCore, *not* CareCore, and stem from alleged wrongdoing during a later, distinct time period. The Court declines, therefore, to dismiss the action under the "public disclosure" bar.

A. COUNTS ONE AND TWO: FALSE CLAIMS

The Court dismisses Counts One and Two because Relators have failed to adequately plead falsity or plead their claims

with sufficient particularity to satisfy Rule 9(b).[5] Under these two subsections of the FCA -- 31 U.S.C. §§ 3729(a)(1)(A) and (B) -- an entity is liable when it either "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval," or "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." United States v. Strock, 982 F.3d 51, 58 (2d Cir. 2020) (quoting 31 U.S.C. §§ 3729(a)(1)(A), (B)). "Claims arising under these two sections are treated similarly, as the primary difference between the two is whether the claim itself is false, § 3729(a)(1)(A), or whether . . . a record or statement material to the claim was false, § 3729(a)(1)(B)." United States v. Omnicare, Inc., No. 15 Civ. 4179, 2021 WL 1063784, at *8 (S.D.N.Y. Mar. 19, 2021).

1. Falsity

Claims under both Sections 3729(a)(1)(A) and (B) "require proof of a falsehood or fraudulent scheme that renders the claim or statement in question 'false.'" United States ex rel. Kester v. Novartis Pharms. Corp., No. 11 Civ. 8196, 2014 WL 2619014, at *4 (S.D.N.Y. June 10, 2014). "The

[5] The Court therefore does not address eviCore's additional arguments for dismissal of these counts, including its arguments that the SAC does not establish knowledge, scienter, or materiality. See, e.g., United States ex rel. Osmose, Inc. v. Chem. Specialties, Inc., 994 F. Supp. 2d 353, 366 n.4 (W.D.N.Y. 2014) ("In light of this Court's conclusions, Defendants' objective falsity and materiality arguments need not be considered at this time.").

FCA recognizes two types of false claims: factually false claims and legally false claims." United States ex rel. Grubea v. Rosicki, Rosicki & Assocs., P.C., 318 F. Supp. 3d 680, 699 (S.D.N.Y. 2018).

Relators' claims here arise from the alleged provision of "worthless services." Worthless services claims are "effectively derivative" of factually false claims. Mikes v. Straus, 274 F.3d 687, 703 (2d Cir. 2001), abrogated by Universal Health Servs., Inc. v. United States, 136 S. Ct. 1989 (2016). These claims assert "the knowing request of federal reimbursement for a procedure with no medical value." Id. at 702; see also United States ex rel. Lee v. SmithKline Beecham, Inc., 245 F.3d 1048, 1053 (9th Cir. 2001) ("[K]nowingly billing for worthless services or recklessly doing so with deliberate ignorance may be actionable under § 3729."). Services are considered "worthless" when "the performance of the service is so deficient that for all practical purposes it is the equivalent of no performance at all." Mikes, 274 F.3d at 703.

Here, Relators assert that eviCore submitted claims "for worthless prior authorization services that were not properly undertaken." (SAC ¶ 170.) Relators likewise argue that the related requests MCOs submitted to the Government for such worthless services were false. (Id. ¶ 178.)

As a threshold matter, the Court rejects eviCore's argument that no "claims" have been alleged. (EviCore's Br. at 11.) The FCA defines a "claim" as "any request or demand . . . for money or property" that is presented, directly or indirectly, to the United States. 31 U.S.C. § 3729(b)(2)(A). Thus, "[f]raudulent claims are actionable not only when they are presented to an 'officer' or 'employee' of the United States, but also when they are presented . . . to a 'contractor, grantee, or other recipient.'" United States v. Wells Fargo & Co., 943 F.3d 588, 595-96 (2d Cir. 2019) (quoting 31 U.S.C. § 3729(b)(2)(A)). The Court therefore rejects eviCore's argument that dismissal is warranted "because MCOs do not submit 'claims' to CMS." (EviCore's Br. at 11.)

Nevertheless, the Court finds that falsity has not been alleged here because the services eviCore provided were not so "worthless" that they were "the equivalent of no performance at all." Mikes, 274 F.3d at 703. In each instance of alleged auto-approval, Relators qualify the auto-approval as limited in one respect or another. For example, Relators allege that around Labor Day 2018, eviCore established "'approve as requested' protocols for *the first three requests* for any course of care." (SAC ¶ 26 (emphasis added).) This alleged policy was thus admittedly limited to only "the

first three requests." Similarly, Relators allege that eviCore directly instructed clinical reviewers to auto-approve "all requests relating to *certain providers, therapies, and populations*." (SAC ¶ 99 (emphasis added).) Likewise, Relators allege that eviCore directed auto-approval for "*pediatric* treatment requests" from Blue Cross Blue Shield Texas due to "provider noise." (SAC ¶ 102 (emphasis added).) While these qualifications do not render eviCore's approval process entirely satisfactory or appropriate, they do undermine Relators' claim that the utilization management and prior authorization services provided were entirely "worthless." Insofar as eviCore provided *some* legitimate prior authorization and utilization managements services, those services were not "the equivalent of no performance at all." Mikes, 274 F.3d at 703; see also United States v. Dialysis Clinic, Inc., No. 09 Civ. 00710, 2011 WL 167246, at *21 (N.D.N.Y. Jan. 19, 2011) (dismissing a worthless services claim because the allegations were not the "equivalent of no performance at all" when plaintiff did not allege "that defendant failed to provide *any* services to their patients"); United States ex rel. Swan v. Covenant Care, Inc., 279 F. Supp. 2d 1212, 1221 (E.D. Cal. 2002) (concluding that "[b]ecause Swan does not allege that Covenant Care's neglect of its patients was so severe that, for all practical purposes,

the patients were receiving no room and board services or routine care at all, her FCA claim does not fit within the worthless services category"); see also Sweeney v. ManorCare Health Servs., Inc., No. 03-5320, 2005 WL 4030950, at *6 (W.D. Wash. Mar. 4, 2005) (finding that the relator's "worthless services theory fails to state a claim" because it did "not allege that [the defendant] failed to provide any services at all," and explaining that "it would be impossible to determine whether particular services [the defendant] provided, and the United States paid for, were worthless without finding that the care as a whole was worthless").

2. Particularity

Relators likewise fail to plead Counts One and Two with sufficient particularity to satisfy Rule 9(b) because the SAC fails "to specify the time, place, speaker, and . . . even the content of the alleged misrepresentations." Wood ex rel. U.S. v. Applied Rsch. Assocs., Inc., 328 F. App'x 744, 748 (2d Cir. 2009) (quoting Luce v. Edelstein, 802 F.2d 49, 54 (2d Cir. 1986)). In Count One, Relators allege that eviCore submitted claims for payment to the Government, via their client MCOs, which were false "because they were for worthless prior authorization services that were not properly undertaken." (SAC ¶ 170.) However, the SAC does not identify *any* records of requests for payment from eviCore to any MCOs

for utilization management or prior authorization services. In other words, Relators fail to "cite to a single identifiable record or billing submission they claim to be false, or give a single example of when a purportedly false claim was presented for payment by a particular defendant at a specific time." Wood, 328 F. App'x at 750.

Likewise, in Count Two, Relators allege that eviCore caused MCOs to submit false claims for "prior authorization services that eviCore either never rendered, or performed in a worthless fashion." (SAC ¶ 175.) But, again, Relators have not identified a single request for payment for prior authorization services, nor have Relators identified who made such requests, when, or where. Such allegations are "plainly insufficient" and fail to meet the "heightened pleading standard of Fed R. Civ. P. 9(b)." Wood, 328 F. App'x at 747, 750.

To the extent Relators' claims are premised on eviCore's alleged approvals of unnecessary medical treatments, these claims fare no better. Relators do not identify any approvals, much less do they allege who approved the unnecessary services, where, or when. While Relators identify a number of individuals involved in the alleged auto-approval scheme, none of these individuals allegedly submitted any of the "false claims" -- either requesting payment for prior

authorization or utilization management services, or approving unnecessary medical treatment. The allegations are therefore insufficient to "provide the defendant with enough details to be able to reasonably discern which of the claims it submitted are at issue." Lab'y Corp., 2015 WL 7292774, at *3 (citation omitted).

Nor is the Court persuaded by Relators' argument that the alleged scheme leads to "a strong inference that specific claims were indeed submitted." (Relators' Br. at 6.) Unlike the facts in Chorches, Relators here do not provide allegations that "detail specific and plausible facts" from which systematic falsification can be "easily" inferred. Chorches, 865 F.3d at 84. To the contrary, the allegations here are confused and contradictory. For example, the Manager of Clinical Review is alleged to have, on the one hand, encouraged and directed inaccurate auto-approvals (SAC ¶¶ 30, 108), and on the other, scrutinized and attempted to correct the practice (id. ¶ 111).

Likewise, while the SAC alleges that the auto-approval processes were designed to approve requests indiscriminately (id. ¶ 21 (describing "swinging gate prior authorization approval process")), it also alleges that the automation software eviCore uses requires *some* "demographic and clinical information" (id. ¶ 89), and suggests that the pathways were,

in at least some cases, developed by knowledgeable clinical reviewers (id. ¶ 142 ("Jane Doe 1 lead a team of pediatric reviewers to develop an authorization decision matrix, based on current medical evidence, literature, and guidelines.").) At best, the SAC alleges a discrete and haphazard set of auto-approval processes that existed at "various times" for "certain categories" of requests. (Id. ¶ 23.) These allegations fall short of alleging a "detailed scheme" from which fraudulent claims can be "easily" inferred. Chorches, 865 F.3d at 84.

Relators correctly point out that the Second Circuit has held that Rule 9(b) may be satisfied by allegations "based on information and belief when facts are peculiarly within the opposing party's knowledge." Boykin v. KeyCorp, 521 F.3d 202, 215 (2d Cir. 2008). However, the Second Circuit has also explained that "[t]his exception to the general rule must not be mistaken for license to base claims of fraud on speculation and conclusory allegations." Wexner, 902 F.2d at 172. Rule 9(b) may be relaxed "where information is *only* within the opposing party's knowledge." Lab'y Corp., 2015 WL 7292774, at *7 (quoting Yuhasz v. Brush Wellman, Inc., 341 F.3d 559, 566 (6th Cir. 2003)).

Here, Relators allege that they "possess personal knowledge and experience regarding eviCore's 'auto-approve'

activities, including personal contact with the employees and executives of eviCore who have planned, initiated and directed the violations of law alleged herein." (SAC ¶ 43.) Thus, Relators do not credibly allege that all specific facts regarding the scheme were exclusively known to eviCore. For these reasons, Counts One and Two are dismissed.

B. COUNT THREE: REVERSE FALSE CLAIMS

Section 3729(a)(1)(G) imposes liability on anyone who "knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government." 31 U.S.C. § 3729(a)(1)(G). To establish a violation of this subsection, "a plaintiff must show: (1) 'proof that the defendant made a false record or statement' (2) at a time that the defendant had a presently-existing 'obligation' to the government -- a duty to pay money or property." Kester, 2014 WL 2619014, at *10 (quoting Chesbrough v. VPA, P.C., 655 F.3d 461, 473 (6th Cir. 2011)); citing Wood, 328 Fed. App'x at 748). Claims under this subsection are known as "reverse false claims" because Section 3729(a)(1)(G) imposes liability for failure to pay money *owed to* the government, rather than for obtaining money

from the government. Omnicare, 2021 WL 1063784, at *2 (citing United States ex rel. Foreman v. AECOM, 454 F. Supp. 3d 254, 268 (S.D.N.Y. 2020)).

Like claims under Sections 3729(a)(1)(A) and (B), reverse false claims under Section 3729(a)(1)(G) require falsity or falsehood to be actionable. Thus, for the same reasons set forth above with respect to Counts One and Two, Count Three also fails. Moreover, the Court is unpersuaded that a reverse false claim may be predicated exclusively on a "decision to retain, rather than return, Government funds," as Relators allege here. (Relators' Br. at 16.)

Courts in this District have repeatedly held that, absent allegations of an independent obligation to pay the government, a reverse false claim is not sufficiently pleaded based only on allegations that a defendant "retain[ed] Government funds to which they were not entitled." Foreman, 454 F. Supp. 3d at 268; see also United States ex rel. Gelbman v. City of New York, No. 14 Civ. 771, 2018 WL 4761575, at *8 (S.D.N.Y. Sept. 30, 2018), aff'd, 790 F. App'x 244 (2d Cir. 2019) ("Relator's reverse false claim allegations -- which essentially boil down to various providers allegedly receiving payment on false claims and thus retaining Government funds to which they were not entitled -- are not an adequate basis on which to allege a reverse false claim.");

Wood, 328 F. App'x at 748 (affirming dismissal of reverse false claim when the complaint contained "no mention of any financial obligation . . . owed to the government, and moreover, d[id] not specifically reference any false records or statements used to decrease such an obligation").

C. COUNT FOUR: CONSPIRACY

Relators do not address this argument in their opposition brief and thus the point is considered waived. See, e.g., Kao v. British Airways, PLC, No. 17 Civ. 0232, 2018 WL 501609, at *5 (S.D.N.Y. Jan. 19, 2018) ("Plaintiffs' failure to oppose Defendants' specific argument in a motion to dismiss is deemed waiver of that issue.").

Moreover, the Court is persuaded by eviCore's argument that Relators have not adequately pleaded a violation of Section 3729(a)(1)(C), which imposes liability on any person who "conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G)." 31 U.S.C. § 3729 (a)(1)(C). "To prove a claim under this subsection, a plaintiff must show: (1) an unlawful agreement by the defendant to violate the FCA, and (2) at least one overt act performed in furtherance of that agreement." Kester, 2014 WL 2619014, at *10 (citing United States ex rel. Grubbs v. Kanneganti, 565 F.3d 180, 193 (5th Cir. 2009); United States ex rel. Sterling v. Health Ins. Plan of Greater N.Y., Inc., No. 06 Civ. 1141, 2008 WL 4449448,

at *4 (S.D.N.Y. Sept. 30, 2008)). To adequately state a conspiracy claim, Relators "must at least allege that two or more people or organizations were involved in the fraud." Sterling, 2008 WL 4449448, at *4. Here, Relators "fail[] to meet the minimal standard to show a conspiracy . . . that more than one person was involved." Id.

D. COUNTS TWENTY-ONE THROUGH TWENTY-TWO: RETALIATION

Under the FCA's anti-retaliation provision, "any employee" shall be entitled to relief who "is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment" in connection with his or her "efforts to stop 1 or more violations of [the FCA]." Chorches, 865 F.3d at 95 (citing 31 U.S.C. § 3730(h)(1)). To sufficiently plead a retaliation claim, a plaintiff must generally establish that "(1) he engaged in activity protected under the statute, (2) the employer was aware of such activity, and (3) the employer took adverse action against him because he engaged in the protected activity." Id.

A "constructive discharge," which Relators seek to allege here, arises when an employer, "rather than discharging [the employee] directly, intentionally creates a work atmosphere so intolerable that he is forced to quit involuntarily." Terry v. Ashcroft, 336 F.3d 128, 151-52 (2d

Cir. 2003) (citations omitted). Such conditions exist when "viewed as a whole, they are 'so difficult or unpleasant that a reasonable person in the employee's shoes would have felt compelled to resign.'" Id. (quoting Chertkova v. Conn. Gen. Life Ins. Co., 92 F.3d 81, 89 (2d Cir. 1996)). Plaintiffs alleging constructive-discharge claims must "show both (1) that there is evidence of the employer's intent to create an 'intolerable' environment that forces the employee to resign, and (2) that the evidence shows that a reasonable person would have found the work conditions so intolerable that he 'would have felt compelled to resign.'" Adams v. Festival Fun Parks, LLC, 560 F. App'x 47, 49-50 (2d Cir. 2014) (citing Petrosino v. Bell Atl., 385 F.3d 210, 229 (2d Cir. 2004)).

Relators here fail to adequately plead constructive discharge. Relators allege that both Jane Doe 1 and Jane Doe 2 were held to their original productivity goals, despite a company-wide reduction for all employees during the COVID-19 pandemic. (See SAC ¶¶ 149, 162.) Likewise, Relators allege that both Jane Doe 1 and Jane Doe 2 were discouraged, or prevented, from attending meetings, and were relieved of certain higher-level responsibilities. As a result, according to Relators, Jane Doe 1 and Jane Doe 2 were "forced to resign." (See id. ¶¶ 150, 163.)

The Court finds that these allegations are not enough to

plausibly allege that eviCore maintained an intentionally intolerable workplace. Relators have not established that the original productivity requirements eviCore allegedly imposed during the pandemic, or their exclusion from certain meetings, were "so difficult or unpleasant that a reasonable person in the employee's shoes would have felt compelled to resign." Adams, 560 F. App'x at 49. Nor, fatally, have the Relators adduced facts supporting the claim that such conditions were created by eviCore with the *intent* of causing either Jane Doe 1 or Jane Doe 2 to resign. E.g., Kader v. Paper Software, Inc., 111 F.3d 337, 341 (2d Cir. 1997) ("[Plaintiff] has demonstrated that an uneasy and stressful environment existed, but he has adduced no evidence to support an inference that his employer intentionally created an intolerable workplace."). Thus, the retaliation claims are also dismissed.[6]

E. COUNTS FIVE THROUGH TWENTY: STATE LAW CLAIMS

The Court declines to exercise supplemental jurisdiction over the state law claims, which it may do under the FCA if

[6] The Court finds persuasive eviCore's argument that the SAC may not allege sufficient facts supporting anonymity. See EviCore's Br. at 23; see also United States v. Pilcher, 950 F.3d 39, 45 (2d Cir. 2020) (explaining that anonymity is "the exception and not the rule, and in order to receive the protections of anonymity, a party must make a case rebutting th[e] presumption [of disclosure]"). Nevertheless, having dismissed the retaliation claims on the grounds set forth herein, the Court will not address eviCore's argument that the SAC should be dismissed on the grounds that Jane Doe 1 and Jane Doe 2 remain anonymous inappropriately.

it "has dismissed all claims over which it has original jurisdiction." 28 U.S.C. § 1367(c)(3). Here, "[h]aving dismissed the federal claims over which the Court has original jurisdiction, the Court declines to exercise its supplemental jurisdiction over any state-law claims Plaintiff may be asserting." Mercer v. Westchester Med. Ctr., No. 21 Civ. 2961, 2021 WL 1864326, at *2 (S.D.N.Y. May 7, 2021) (citing Kolari v. N.Y.-Presbyterian Hosp., 455 F.3d 118, 122 (2d Cir. 2006) ("Subsection (c) of § 1367 'confirms the discretionary nature of supplemental jurisdiction.'") (quoting City of Chicago v. Int'l Coll. of Surgeons, 522 U.S. 156, 173 (1997)). Moreover, "[w]here Relator has not sufficiently pled its allegations in any state, it would be illogical to allow those deficient allegations to support state-law claims." Lab'y Corp., 2015 WL 7292774, at *7.

F. STATUTE OF LIMITATIONS

The Court rejects eviCore's argument that because the initial complaint was filed under seal, eviCore "ha[d] no basis to determine if the SAC relates back to the allegations in the initial complaint under Rule 15(c)(1)(B)," and therefore all claims "six years before the FAC was filed in this matter are barred." (EviCore's Br. at 23.) The initial complaint was unsealed on June 10, 2020 (see Dkt. No. 36), months before eviCore filed the instant Motion. The Court is

therefore not persuaded that eviCore has been denied the opportunity to determinate whether the SAC relates back to the initial complaint under Rule 15. Nor would the Court find claims time-barred on the sole ground that the initial complaint in an action was sealed. See, e.g., Hayes v. Dep't of Educ., 20 F. Supp. 3d 438, 444 (S.D.N.Y. 2014) (explaining that "[a] relator may commence a qui tam action unilaterally, but after the action is brought cannot influence when the complaint is ultimately unsealed," and "[t]here is no valid reason to punish an otherwise diligent relator by stripping away claims when the Government, not the relator, is to blame for preventing the defendant from receiving notice of the action against it" (internal citations omitted)).

G. LEAVE TO AMEND

The Court grants Relators leave to amend the SAC. Leave to amend should be given freely "when justice so requires." Fed. R. Civ. P. 15(a)(2). Leave should be denied "in instances of futility, undue delay, bad faith or dilatory motive, repeated failure to cure deficiencies by amendments previously allowed, or undue prejudice to the non-moving party." Burch v. Pioneer Credit Recovery, Inc., 551 F.3d 122, 126 (2d Cir. 2008) (citing Foman v. Davis, 371 U.S. 178, 182 (1962)). "A district court has broad discretion in determining whether to grant leave to amend." Gurary v.

Winehouse, 235 F.3d 792, 801 (2d Cir. 2000), cert. denied, 534 U.S. 826 (2001).

Here, Relators have already amended the complaint twice, and have therefore had some opportunity to address the deficiencies therein. See, e.g., Ladas, 824 F.3d at 28-29. Nevertheless, the previous amendments were not in response to motions to dismiss. See, e.g., Polansky, 2009 WL 1456582, at *10 (granting leave to replead when "[the relator] has amended his complaint on three prior occasions, [but] it was not in response to a motion by Pfizer" and "[i]nstead, it occurred during the period when the complaint was sealed while the United States Attorney was making a judgment as to whether to intervene"). Now that Relators are apprised of their pleading failures, the Court grants leave to further amend the SAC.

IV. ORDER

For the reasons set forth above, it is hereby

ORDERED that the motion of defendant eviCore Healthcare MSI to dismiss the Second Amended Complaint of plaintiffs United States of America *ex rel.* SW Challenger, LLC ("Relators") (Dkt. No. 21) is **GRANTED** and Relators' claims are dismissed without prejudice.

SO ORDERED.

Dated: New York, New York
13 August 2021

Victor Marrero
U.S.D.J.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA, et al., ex rel. SW CHALLENGER, LLC, et al.,

Plaintiffs,

-against-

EVICORE HEALTHCARE MSI, LLC,

Defendant.

19 Civ. 2501 (VM)

ORDER

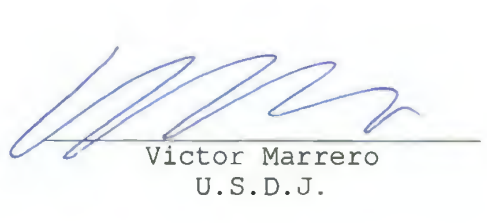
VICTOR MARRERO, United States District Judge.

On August 13, 2021, the Court granted defendant eviCore Healthcare MSI, LLC's ("Defendant") motion to dismiss the Second Amended Complaint ("SAC") from plaintiff relator SW Challenger, LLC, on behalf of the United States and several individual states (collectively, "Relators") (Dkt. No. 44.) The Court granted leave for the Relators to further amend the SAC. (Id.) On February 7, 2022, Relators notified the Court they do not intend to replead and request final judgment be entered so they may effectuate an appeal. (Dkt. No. 46.)

IT IS HEREBY ORDERED, in accordance with the Court's August 13, 2021, Decision and Order (Dkt. No. 44), the Clerk of Court is directed to terminate all pending motions and enter final judgment in favor of eviCore Healthcare MSI, LLC.

SO ORDERED.

Dated: February 8, 2022
New York, New York



Victor Marrero
U.S.D.J.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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UNITED STATES OF AMERICA, et al., ex rel.
SW CHALLENGER, LLC, et al.,

Plaintiffs,

-against-

19 **CIVIL** 2501 (VM)

JUDGMENT

EVICORE HEALTHCARE MSI, LLC,

Defendant.

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It is hereby **ORDERED, ADJUDGED AND DECREED:** That for the reasons stated in the Court's Order dated February 8, 2022, the Court granted defendant eviCore Healthcare MSI, LLC's motion to dismiss the Second Amended Complaint ("SAC") from plaintiff relator SW Challenger, LLC, on behalf of the United States and several individual states. The Court granted leave for the Relators to further amend the SAC. On February 7, 2022, Relators notified the Court they do not intend to replead and request final judgment be entered so they may effectuate an appeal. In accordance with the Court's August 13, 2021, Decision and Order, final judgment is entered in favor of eviCore Healthcare MSI, LLC.

Dated: New York, New York

February 10, 2022

RUBY J. KRAJICK

Clerk of Court

BY: K. Mango

Deputy Clerk

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA, *et al.*, *ex rel.* SW CHALLENGER, LLC, JANE DOE 1, and JANE DOE 2, Plaintiffs, v. EVICORE HEALTHCARE MSI, LLC, Defendant.	NOTICE OF APPEAL No. 19 Civ. 2501 (VM)

Notice is hereby given that SW Challenger, LLC; Jane Doe 1; and Jane Doe 2, plaintiffs in the above-captioned case, hereby appeal to the United States Court of Appeals for the Second Circuit from the final judgment entered in this action on February 10, 2022 (ECF No. 49), dismissing the Second Amended Complaint (ECF No. 15) in accordance with the Decision and Order entered on August 13, 2021 (ECF No. 44) and the Order entered on February 8, 2021 (ECF No. 48).

Dated this 14th day of March, 2022

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CERTIFICATE OF SERVICE

I do hereby certify that, on March 14, 2022, a true and correct copy of the foregoing was electronically filed with the Clerk of Court and served on all counsel of record through the Court's CM/ECF system.

/s/ Stephen A. Weiss
Stephen A. Weiss