UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

UNITED STATES, ex rel. DR. SUSAN NEDZA, Relator, v. AMERICAN IMAGING MANAGEMENT, INC., et al., Defendants.	Case No. 15-cv-6937 Judge Alonso Magistrate Judge Cox

NOTICE OF FILING OF SUPPLEMENTAL AUTHORITY IN SUPPORT OF DEFENDANTS' MOTIONS TO DISMISS

Pursuant to the Court's July 19, 2018 order (Dkt. 201), the undersigned Defendants hereby submit additional authority in support of Defendants' Motions to Dismiss and state as follows with respect to this authority:

In her July 16th Motion for Leave to Submit Supplemental Authority in Support of her Response to Defendants' Motions to Dismiss (Dkt. 199), Relator asserted that a Ninth Circuit panel's recent *Silingo* decision addressed a "factually analogous" case regarding fraud in the Medicare Advantage ("MA") program and, therefore, is relevant to the issues in the pending motions to dismiss. *Id.* at 2 (citing *United States ex rel. Silingo v. Wellpoint, Inc.*, No. 16-56400, 2018 WL 3341038 (9th Cir. July 9, 2018). However, as discussed in open court, the case in *Silingo* is not factually analogous to the case at hand. *See* Third Amended Complaint, *United States ex rel. Silingo v. Wellpoint, Inc.*, No. 16-56400, (N.D. Cal. Oct. 10, 2015), ECF No. 81 (Attached as Exhibit A) ("*Silingo* Complaint"). Among other things,[1] the *Silingo* Complaint,

[1] For example, the Ninth Circuit has ruled that "a complaint need not distinguish between defendants that had the exact same role in a fraud" and who engaged in "precisely the same conduct." *Silingo*, 2018 WL 3341038 at

particularly beginning at Paragraph 77, contains significantly more detailed allegations than Relator alleges in her Second Amended Complaint, here ("SAC"). While both are MA cases, the *Silingo* Complaint contains far more of the "who, what, when, where, and how" than Relator has thrice alleged to this Court. Unlike Relator's SAC, the *Silingo* Complaint alleges a scheme in which each of a handful of defendant MA plans paid a vendor (MedXM) for the sole purpose of creating (allegedly fraudulent) diagnostic data to be submitted to the Medicare program, for the sole purpose of directly increasing government payouts to those plans beyond what otherwise would have been paid in the normal course. In contrast, here, Relator's SAC alleges that an admittedly-legitimate service provided by American Imaging Management, Inc. ("AIM")—utilization management—became knowingly fraudulent as to 27 different MA plan Defendants simply because AIM's denial rates for certain imaging procedures stood "as high as" 5-9% for unspecified defendant health plans, as opposed to 1-2%. SAC ¶¶ 7, 48, 92.

For these and other reasons stated in open court on July 19, 2018, *Silingo* has little relevance to Relator's generic allegations against the MA Plan Defendants here and the pending motions to dismiss her SAC.

Dated: July 20, 2018

Respectfully submitted,

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*6 (citing *United States ex rel. Swoben v. United Healthcare Ins. Co.*, 848 F.3d 1161 (9th Cir. 2016)). Now, a Ninth Circuit panel has sustained the *Silingo* Complaint on that basis. Similar precedent does not exist in this Circuit.

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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, *ex rel.* ANITA SILINGO,

Plaintiffs,

vs.

MOBILE MEDICAL EXAMINATION SERVICES, INC., a California corporation; MEDXM, a business entity, form unknown; WELLPOINT, INC., an Indiana corporation; ANTHEM BLUE CROSS, business entity, form unknown; ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, a California corporation; BLUE CROSS OF CALIFORNIA, a California corporation; HEALTH NET, INC., a Delaware corporation; HEALTH NET OF CALIFORNIA, INC., a California corporation; HEALTH NET LIFE INSURANCE COMPANY, a California corporation; VISITING NURSE SERVICE OF NEW YORK, a New York corporation; VISITING NURSE SERVICE CHOICE, business organization, form unknown; MOLINA HEALTHCARE, INC., a Delaware corporation; MOLINA HEALTHCARE OF CALIFORNIA, a California corporation; MOLINA HEALTHCARE SERVICES, a California corporation; MOLINA

Case No. CV13-1348 FMO(SHx)

THIRD AMENDED COMPLAINT FOR VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT, AND CALIFORNIA LABOR CODE SECTIONS 201, ET SEQ.; REQUEST FOR JURY TRIAL

HEALTHCARE OF CALIFORNIA PARTNER PLAN, INC., a California corporation; ALAMEDA ALLIANCE FOR HEALTH, a business organization, form unknown,

Defendants.

COMES NOW, Plaintiff and Qui Tam Relator Anita Silingo, individually and on behalf of the United States of America, and alleges as follows:

JURISDICTION AND VENUE

1. Plaintiff and Qui Tam Relator Anita Silingo (Relator) files this action on behalf and in the name of the United States Government (Government) seeking damages and civil penalties against the defendants for violations of 31 U.S.C. § 3729(a). Relator also files this action on her own behalf seeking damages and other remedies against certain defendants for violations of 31 U.S.C. § 3730(h) and *California Labor Code* §§ 201, et seq.

2. This Court's jurisdiction over the claims for violations of 31 U.S.C. §§ 3729(a) and 3730(h) is based upon 31 U.S.C. § 3732(a). The Court's jurisdiction over the claims for violations of *California Labor Code* §§ 201, et seq. is based upon 28 U.S.C. § 1367(a).

3. Venue is vested in this Court under 31 U.S.C. § 3732(a) because at least one of the defendants transacts business in the Central District of California and many acts constituting violations of 31 U.S.C. § 3729(a) occurred in the Central District of California. Venue is also vested in this Court under 28 U.S.C. § 1391(b) because at least one of the defendants transacts business in the Central District of California and many acts constituting violations of 31 U.S.C. § 3730(h) occurred in the Central District of California.

THE PARTIES

4. Relator is a citizen of the United States and a resident of the State of California. Relator brings this action of behalf of the Government under 31 U.S.C. § 3730(b), and on her own behalf under 31 U.S.C. § 3730(h) and *California Labor Code* §§ 201, et seq.

5. At all times relevant, the Government funded the Medicare program which provides payment of healthcare services for, among others, those 65 years or older. The

Government provided a Medicare option known as Medicare Advantage (MA), previously known as Medicare+Choice, in which eligible Medicare beneficiaries can enroll with a managed care organization or health maintenance organization (collectively, "MAO") contracted with the Government for a capitated rate paid by the Government that would provide at least those services provided to standard Medicare beneficiaries.

6. At all times relevant, defendant Mobile Medical Examination Services, Inc. is and was a corporation formed under the laws of the State of California, and transacted business in, among other places, the Central District of California. At all times relevant, defendant MEDXM is a business entity, form unknown, and transacted business in, among other places, the Central District of California. All defendants referenced in this paragraph are collectively referred to in this Complaint as "MedXM."

7. At all times relevant, MedXM contracted with various MAOs, including but not limited to the other defendants in this action, to perform physical medical examinations of such MAOs' MA patients at their residence for purposes of documenting HCC risk adjustment scores. In turn, MedXM retained physicians, nurse practitioners and physician assistants as independent contractors to perform such physical medical examinations.

8. At all times relevant, defendant Wellpoint, Inc. is and was a corporation formed under the laws of the State of Indiana, and transacted business in, among other places, the Central District of California. At all times relevant, defendant Anthem Blue Cross, previously sued as Anthem Blue Cross and Blue Shield, is and was a business entity, form unknown, and transacted business in, among other places, the Central District of California. At all times relevant, defendants Anthem Blue Cross Life and Health Insurance Company and Blue Cross of California are and were corporations formed under the laws of the State of California, and transacted business in, among other places, the Central District of California. All defendants referenced in this paragraph are collectively referred to in this Complaint as "Wellpoint."

9. At all times relevant, defendant Health Net, Inc. is and was a corporation formed under the laws of the State of Delaware, and transacted business in, among other places, the Central District of California. At all times relevant, defendants Health Net of California, Inc.

and Health Net Life Insurance Company are and were corporations formed under the laws of the State of California, and transacted business in, among other places, the Central District of California. All defendants referenced in this paragraph are collectively referred to in this Complaint as "Health Net."

10. At all times relevant, defendant Visiting Nurse Service of New York is and was a corporation formed under the laws of the State of New York. At all times relevant Visiting Nurse Service Choice is and was a business organization, form unknown. All defendants referenced in this paragraph are collectively referred to in this Complaint as "VNS."

11. At all times relevant, Molina Healthcare, Inc. is and was a corporation formed under the laws of the State of Delaware, and transacted business in, among other places, the Central District of California. At all times relevant Molina Healthcare of California, Molina Healthcare Services, and Molina Healthcare of California Partner Plan, Inc. are and were California corporations, and transacted business in, among other places, the Central District of California. All defendants referenced in this paragraph are collectively referred to in this Complaint as "Molina."

12. At all times relevant, defendant Alameda Alliance for Health (Alameda) is and was a business organization, form unknown.

13. At all times relevant, Wellpoint, Health Net, VNS, Molina, and Alameda are and were managed care organizations that contracted with the Government as MAOs. The defendants referenced in this paragraph are collectively referred in this Complaint as "defendant Health Plans."

14. Relator was employed with MedXM between August 2011 and June 2013, initially as an independent contractor, and then as an employee during and after January 2012. Relator held the position of Director of Provider Relations throughout her employment with MedXM. Relator was also designated as MedXM's Compliance Officer from about late spring/early summer of 2012 until or about April 1, 2013.

15. At all times relevant, MedXM contracted with MA health plans, including the defendant Health Plans, to perform in-home health assessments of MA enrollees of MedXM's

MA health plan clients, including the defendant Health Plans. Pursuant to these contracts, the MA health plans advised MedXM which MA enrollees were to undergo in-home health assessments using agreed-upon health assessment forms. In turn, MedXM contracted with various physicians, nurse practitioners, and physician assistants (collectively, "medical examiners") to perform such in-home health assessments, and each of MedXM's MA health plan clients, including the defendant Health Plans, advised MedXM which of its contracted medical examiners were authorized to perform health assessments of such MA health plan's MA enrollees.

Risk Adjustment

16. At all times relevant, Section 1853(a)(3) of the Social Security Act [42 U.S.C. § 1395w-23(a)(3)] required the Government's Centers for Medicare and Medicaid Services (CMS) to risk adjust payments to Medicare Advantage organizations (MAOs), such as the defendant Health Plans. In general, the risk adjustment methodology relied on enrollee diagnoses, as specified by the International Classification of Disease, Ninth Revision Clinical Modification (ICD-9) guidelines, to prospectively adjust capitation payments for a given enrollee based on the health status of the enrollee. Diagnosis codes (ICD-9 codes) and related information (collectively, "risk adjustment data") submitted by MAOs, such as the defendant Health Plans, to CMS were used to develop Hierarchical Condition Category (HCC)[1] risk adjustment scores that are used by CMS to adjust the capitated payment rates paid by the Government to that particular MAO. The HCC risk adjustment scores compensated a MAO with a population of patients with more severe illnesses than normal through higher capitation rates. Likewise, a MAO with a population of patients with less severe illnesses than normal would see a downward adjustment of its capitation rates because it was servicing a healthier than normal population of patients. By risk adjusting MAO payments, CMS attempts to make appropriate and accurate payments for enrollees with differences in expected healthcare costs.

[1]Not all diagnoses result in a HCC risk adjustment score. Only certain diagnosis codes or combinations thereof result in HCC risk adjustment scores. A HCC risk adjustment score will vary upon the diagnosis codes or combinations thereof according to a matrix determined by the Government.

Risk adjustment data records the health status and demographic characteristics of an enrollee. This process was phased in beginning in or about 2005 and was completed by or about the end of the 2008 risk adjustment data submissions.

17. In order to obtain an HCC risk adjustment score for a MA enrollee for a given year, the enrollee must have an encounter with a medical provider or examiner that generates a diagnosis code or codes, which were timely submitted to CMS. If a MA enrollee does not have a reported encounter with a medical provider or examiner that generates a diagnosis code during the year, the following year CMS will pay the MAO a lower capitated rate for that MA enrollee as though s/he was perfectly healthy, even though in prior years the MA enrollee had a diagnosis or diagnoses that resulted in significant HCC risk adjustment scores and correspondingly higher capitation rates.

Risk Adjustment Data Must Be Supported by Properly Documented Medical Records

18. Risk adjustment data (RAD) submitted by or on behalf of a MAO to CMS must be supported by properly documented medical records from the encounter that led to the RAD.[2] In order to be a properly documented medical record, the medical record entries must, among other things, (1) be the result of a MA enrollee's face-to-face encounter with a medical provider or examiner legally authorized to perform the service rendered under applicable Medicare laws, regulations and rules,[3] (2) that accurately and truthfully documents the findings necessary to support the medical diagnoses by the medical provider/examiner in accordance

[2] 42 C.F.R. §§ 422.310(c)(2) and (d), 422.504(l); Medicare Managed Care Manual, Ch. 7, § 40 [Medicare Advantage Organizations "must . . . [e]nsure the accuracy and integrity of risk adjustment data submitted to CMS. All diagnosis codes must be documented in the medical record and must be documented as a result fo a face-to-face visit. . . ."]; *see also*, 79 Fed.Reg. No. 100, 29844, 29923 (May 23, 2014) ["Further, CMS has required for many years that diagnoses that MA organizations submit for payment be supported by medical record documentation."]

[3] *See*, Medicare Managed Care Manual, Ch. 7, § 40 ["All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit. . . . "]; 42 U.S.C. § 1395x(r) , (aa)(5)(A), (aa)(6); 42 C.F.R. §§ 410.20(b), 410.74(a)(2), 410.75(b)-(c), made applicable to Medicare Advantage by 42 C.F.R. §§ 422.101(b)(2) and 422.310(d).

with applicable Medicare laws, regulations and rules,[4] and (3) signed by the medical provider/examiner as required by Medicare.[5] Further, the diagnoses must be coded in accordance with all applicable national guidelines, including but not limited to International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting, and the American Health Information Management Association (AHIMA) national guidelines for ethical coding.[6] Failure to meet any of these required elements results in the medical record not being properly documented and being unable to support RAD arising therefrom, and the RAD being invalid.

DEFENDANTS' FRAUDULENT MISCONDUCT

MedXM's Fraudulent Scheme

19. In an effort to generate more in-home health assessment business from MAOs, including the defendant Health Plans, MedXM conceived and operated a fraudulent scheme of submitting false and/or improperly supported RAD to the defendant Health Plans by improperly converting the MA enrollees' prior medical diagnoses into current medical diagnoses and including them in their health assessment reports, and by fabricating and/or exaggerating the severity of the reported diagnoses in order to increase the patients' HCC risk adjustment scores, and thus increasing CMS' capitated payments to MedXM's clientele, including the defendant Health Plans. To carry out this scheme, MedXM routinely violated

[4] 42 C.F.R. §§ 422.310(c)(2) and (d), 422.504(l)(2)-(3); CMS Pub.100-08, Medicare Program Integrity Manual, Ch. 3, §3.3.2.5; International Classification of Disease 9th Revision Guidelines (ICD-9), made applicable to Medicare Advantage by 42 C.F.R. §§ 422.101(b)(2) and 422.310(d), and Medicare Managed Care Manual, Ch. 7, § 40 ["The diagnosis must be coded according to International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting."]

[5] Medicare Program Integrity Manual, Ch. 3, §3.3.2.4, made applicable to Medicare Advantage by 42 C.F.R. §§ 422.101(b)(2) and 422.310(d).

[6] 42 C.F.R. § 422.310(d)(1) ["MA organizations must submit data that conform to CMS' requirements for data equivalent to Medicare fee-for-service data, when appropriate, and to all relevant national standards. . . ."]; Medicare Managed Care Manual, Ch. 7, § 40 ["The diagnosis must be coded according to International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting."]; AHIMA 2009, Amendments, Corrections ans Deletions in the electronic Health Record: Toolkit, pp. 1-8, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_044678.hcsp?dDocName=bok1_044678; Medicare Program Integrity Manual, Ch. 3, § 3.3.2.5(A)-(B).

CMS regulations and guidelines requiring that (a) the MedXM medical examiners provide valid signatures authenticating the entries in the MedXM health assessment reports underlying the RAD submitted to CMS, (b) entries onto the MedXM health assessment reports preserve the original entries made by the medical examiner, and any deletions, additions or other changes be clearly identified as such, (c) RAD be obtained as a result of a face-to-face encounters, (d) diagnoses be supported by properly documented medical records, and (e) MedXM medical examiners comply with federal and state licensure laws.

Improper Electronic Signatures/Unlocked Medical Records/Improper Alterations

20. MAOs must submit RAD to CMS that conform to CMS' requirements for data equivalent to Medicare fee-for-service data and to all relevant national standards. (*See*, 42 C.F.R. § 422.310(d)(1).) At all times relevant, CMS required (and MedXM knew of the requirement that) medical record entries be authenticated by a handwritten or valid electronic signature, and that once signed, electronic medical records be locked, such as in pdf file format, so that the contents therein cannot be modified except by an appropriately authenticated addendum, amendment, correction or deletion in accordance with accepted medical record-keeping standards and CMS' requirements.[7] However, MedXM's contracted medical examiners prepared health assessment reports in electronic form utilizing a computer template (supplied by MedXM) as unlocked Microsoft Word documents. The template only permitted the medical examiner/author's name to be typewritten, and did not permit the medical examiner/author to place a CMS-required electronic digital signature. MedXM's medical examiners transmitted by email such unlocked medical records to MedXM, which were then reviewed by MedXM coders. As discussed in detail below, the defendant Health Plans either had actual knowledge, or acted with reckless disregard for the truth in failing to

[7] *See*, Medicare Program Integrity Manual, Ch. 3, § 3.3.2.4 and (E)["For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. . . . [¶] Providers using electronic systems need to recognize that there is a potential for misuse or abuse with alternate signature methods. . . . [P]roviders need a system and software products that are protected against modification, etc., and should apply adequate administrative procedures that correspond to recognized standards and laws."]; Medicare Program Integrity Manual, Ch. 3, § 3.3.2.5(A) and (B); *see also*, AHIMA 2009, E-signature Model Policy Considerations, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1045551.hcsp?dDocName=bok1045551.

determine in advance of contracting with MedXM, that MedXM's health assessments were not signed by medical examiners as required by CMS, MedXM did not use an appropriate electronic health record (EHR) system and did not implement appropriate EHR documentation policies and procedures to ensure compliance with AHIMA's and CMS' medical record-keeping practices and requirements that preserved and authenticated all of the entries in the EHR health assessment reports.

21. CMS requires (and at all times relevant MedXM knew of the requirement that) entries in EHRs bear the author's signature in certain authorized formats. Although encrypted digital signatures are permitted, simply typing the name of the author on the document is not permitted.[8] All health assessment reports and other medical records prepared by MedXM's medical examiners were prepared on Word documents and only bore the typed names of its medical examiners, and did not bear a CMS-required electronic digitally encrypted signature because MedXM did not supply electronic digitally encrypted signature software to its medical examiners. CMS regulations call for (and at all time relevant MedXM knew that) RAD based upon medical records not bearing an authenticating signature to be disregarded.[9]

22. When viewed on a computer monitor or printed on paper, an electronic digitally encrypted signature will bear telltale indicators indicating that signature is authentic and digitally encrypted. Additionally, a CMS-approved electronic signature must inform the recipient that an electronic signature is being used by indicating so with terms, including but not limited to: "Electronically signed by," "Authenticated by," "Sealed by," "Data entered by," "Approved by," "Verified by," etc., and when dealing with an addendum to a previously electronically signed medical record the data and time of the CMS-approved electronic

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[8] *See*, Medicare Program Integrity Manual, Ch. 3, § 3.3.2.4. (D)-(E); "Electronic Signature, Attestation and Authorship (Updated)," Journal of AHIMA Vol. 80, No. 11 (November-December 2009), http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_045551.hcsp?dDocName=bok1_045551.

[9] *See, Id.; also,* CMS Risk Adjustment Data Validation (RADV) Medical Record Checklist and Guidance, https:www.cms.govmedicaremedicare-advantageplan-paymentdownloadsradvchecklist.pdf.

signature must also be included.[10]

23. The MedXM health assessment reports performed on behalf of the defendant Health Plans (which formed the basis of the RAD MedXM submitted to the defendant Health Plans, who in turn submitted such RAD to CMS) did not have valid signatures in accordance with CMS requirements. As a result, the RAD from such health assessment reports were not supported by properly documented medical records (i.e., health assessment reports), and thus should not have been submitted by or on behalf of the defendant Health Plans to CMS to risk adjust CMS' capitated payments to the defendant Health Plans for the MA enrollees that were the subject of such health assessment reports. At all times relevant, MedXM knew or should have known that the submission of RAD arising from MedXM health assessment reports to the defendant Health Plans and/or CMS was not permitted because MedXM's health assessment reports bore only the typewritten names of the MedXM medical examiners and did not bear required actual or digitally encrypted signatures of the MedXM medical examiners.

24. During and between 2010 and 2014, MedXM sent its health assessment reports to the defendant Health Plans on an ongoing daily basis. The MedXM health assessment reports only bore the medical examiner's typewritten name, and not a signature permitted by CMS.

25. The American Health Information Management Association (AHIMA) national guidelines for ethical coding require that when a medical record is amended, the historical integrity of the original prior record be maintained so that the clarifying addition or amendment can easily be distinguished from the information on the original medical record.[11] MedXM knew or should have known that AHIMA and CMS guidelines also prohibit MedXM from recommending or suggesting to its medical examiners a new diagnosis not previously

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[10] *See,* "Electronic Signature, Attestation and Authorship (Updated)," *supra;* Medicare Program Integrity Manual, Ch. 3, § 3.3.2.4(E).

[11] "Managing an Effective Query Process," Journal of AHIMA, Vol. 79, No. 10 (October 2008) at pp. 83-88; "Guidelines for Achieving a Compliant Query Practice," Journal of AHIMA 84, No. 2 (February 2013) at pp. 50-53; "Guidelines for Achieving a Complaint Query Practice," Journal of AHIMA, Vol. 84, No. 2 (February 2013) at pp. 50-53.

raised or presented by the reviewed medical records.[12] AHIMA and CMS guidelines require each modification or amendment be appropriately signed and dated by the author.[13] AHIMA guidelines also require that all original content must be clearly preserved, not deleted, and provide an acceptable methodology for preserving the original documentation.[14] CMS will not consider additional medical record entries, clarifications, corrections or deletions that are not performed in accordance with medical record documentation practices and CMS requirements that clearly identify the author, time and reason for the addition or alteration of the medical record.[15] At all times relevant, MedXM knew or should have known of the requirements and restrictions mentioned in this paragraph.

26. MedXM knowingly and routinely ignored these documentation requirements. MedXM coders instructed the MedXM medical examiners to improperly modify the health assessment reports performed on the defendant Health Plans' MA enrollees. MedMX coders advised the originating MedXM medical examiners how to modify the unlocked medical records in order to increase the severity of the patients' diagnoses, in an effort to increase the patients' HCC risk adjustment scores, and thus capitated payments by Medicare to the defendant Health Plans. The originating MedXM medical examiners then modified the

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[12]AHIMA "Guidelines for Achieving a Complaint Query Practice." Journal of AHIMA 84, No.2 (February 2013), at pp. 50-53.

[13]AHIMA 2009, E-signature Model Policy Considerations, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_045551.hcsp?dDocName=bok1_045551; Medicare Program Integrity Manual, Ch.3 §3.3.2.5(A)-(B).

[14]*See,* AHIMA 2009, Amendments, Corrections and Deletions in the Electronic Health Record: Toolkit, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok_1044678.hcsp?dDocName=bok1_044678; *see also,* AHIMA 2009, E-signature Model Policy Considerations, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_045551.hcsp?dDocName=bok1_045551.

[15]Medicare Program Integrity Manual Ch. 3, § 3.3.2.5(A)-(B), ["The MACs, CERT, Recovery Auditors, and ZPICs **shall NOT consider any entries that do not comply with the principles listed in section B below, even if such exclusion would lead to a claim denial....** Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted .... containing amendments, corrections or addenda must: (1.) Clearly and permanently identify any amendment, correction or delayed entry as such, and (2.) Clearly indicate the date and author of any amendment, correction or delayed entry, and (3.) Not delete but instead clearly identify all original content." (Emphasis added)]; *also,* AHIMA 2009, E-signature Model Policy Considerations, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_045551.hcsp?dDocName=bok1045551.

unlocked medical records per the MedXM coders' instructions and recommendations, and resubmitted the modified unlocked electronic medical records to MedXM.

27. When making the above-described alterations, the MedXM medical examiners deleted entire sections of the unlocked health assessment reports in violation of the AHIMA guidelines requirement to preserve the original text. The deleted text was replaced with new text that supported an additional and/or higher HCC diagnoses. None of the new additional documentation was properly signed nor dated by the originating MedXM medical examiner.

28. After MedXM's coders decided that the unlocked medical reports contained information supporting the diagnosis codes resulting in the highest HCC risk adjustment scores for the examined patients, MedXM's coders then inserted diagnosis codes onto the health assessment reports (without indicating thereon that these additions were added by the coders) so that it appeared as though such codes were already on the reports when they were purportedly "signed" by the author. (As discussed above, the author's typed name does not comply with CMS electronic signature requirements.) These health assessment reports, as modified by the coders, were then converted into pdf file format and submitted to the appropriate MAO, including the defendant Health Plans. The MAO's including the defendant Health Plans, submitted to CMS the RAD purportedly supported by the health assessment reports.

29. While employed with MedXM, Relator became aware that MedXM coders were improperly instructing MedXM's medical examiners (that prepared and sent to MedXM the health assessment reports and other medical records in unlocked Word documents) replace entire portions of the health assessment reports and other entries with new entries recommended by MedXM's coders, and/or recommending or suggesting to MedXM's medical examiners a new diagnosis not previously raised or presented by the reviewed health assessment reports. The authors of such health assessment reports made the recommended changes to their medical examination reports and other medical records (which were kept as unlocked Word documents) and then resubmitted them to MedXM. The resubmitted documents had no indication of the original chart note or entry in violation of CMS regulations

and AHIMA guidelines. Approximately 60% of the health assessment reports and other medical records that MedXM submitted to its MAO clients, including the defendant Health Plans, were medical records that were altered as described in this paragraph.

Health Assessments Performed by NPs and PAs in Violation of Federal and State Laws

30. Since at least 2010, MedXM has relied heavily on agreements with allied health professionals such as nurse practitioners (NPs) and physician assistants (PAs) to perform health assessments.

31. In states such as California and New York, approximately 50% to 60% of MedXM's medical examiners are PAs or NPs. Twenty-two (22) states (including California and New York) require that NPs must work under the supervision and control of a licensed physician who is responsible for their work, and all states require that PAs perform their duties under the direction and control of a supervising licensed physician who is responsible for their work.

32. As a condition of receiving payment, federal law requires that NPs who provide services to Medicare beneficiaries must do so in collaboration with a licensed Medicare Physician and in compliance with all state law licensure requirements and restrictions. Failure to comply with any state law, or physician control and supervision requirement, renders the NPs' services outside of their scope of practice. (*See*, 42 C.F.R. § 410.75; Medicare Benefit Policy Manual, Ch.15 § 200.) Similarly, as a condition of receiving payment, federal law requires that PAs who render services to Medicare beneficiaries must do so under the direction and control of a Medicare physician. Failure of PAs to comply with any state law licensure restrictions renders the service outside their scope of practice for Medicare. (*See*, 42 C.F.R. § 410.74; Medicare Benefit Policy Manual, Ch.15 § 190.) Risk adjustment data collected by such allied health care providers in violation of their physician supervision requirements is therefore invalid for risk adjustment data purposes. (See, 42 C.F.R. § 422.310.)

33. As will be explained detail below, a majority of MedXM's health assessments were performed by NPs and PAs in violation of their state and federal physician supervision requirements. MedXM submitted theses assessment reports with invalid risk adjustment data

to their contracted health plans including the defendant Health Plans, who in turn submitted the health assessment reports or risk adjustment data derived therefrom to CMS in order to increase their monthly capitation payments from the Government.

34. When Relator began her employment with MedXM, Relator was informed by MedXM senior management that MedXM's agreements with NPs and PAs did not require a supervising physician because such allied health professionals were just performing assessments and were not providing any medical care.

35. Before 2012, MedXM contracted directly with NPs and PAs, and did not know the existence, identity or credentials of any of their supervising physicians regardless of which state such allied health professional was working in. Further, MedXM did not require any documentation to validate that such NP or PA was in fact being supervised in accordance with state law. During 2012, Relator learned that MedXM was incorrect regarding the purported lack of need of a supervising physicians for MedXM NPs and PAs.

36. Before 2012, MedXM had no documentation validating that its NPs were working under the supervision of collaborating physician and/or under the direction and control of a supervising physician as required federal and some state laws. In 2012, Ohio area NPs insisted that MedXM maintain physician collaboration agreements in accordance with Ohio state law. MedXM assisted in arranging many of these agreements, knowing that they were sham arrangements and/or credentials for NPs and PAs that worked in Ohio because no meaningful supervision or collaboration of the NPs and PAs occurred. MedXM's practice was in violation of Ohio state law and federal law governing NPs and PAs:

i. Beginning in or about the latter half of 2012, MedXM had its Ohio NPs sign Standard Care Agreements that were also signed by some of MedXM's contracted physicians, including but not limited to Carol Beck, M.D., James Clark, M.D., and Charles Jenkins, M.D., as collaborating physicians, even though such physicians did not, nor intended to, supervise or direct any of the NPs or comply with their obligations under Ohio Revised Code Section 4723.431. Such

> Agreements falsely indicated that such Ohio NPs were and would perform services under the direction and supervision of the collaborating physicians. These representations were false because the health assessments were performed by such Ohio NPs who were not under the supervision of a licensed physician as required by state law. Further, Ohio Revised Code Section 4723.431 requires a Standard Care Agreement be on file at each site where the NP practices, precluding Ohio NPs from legally providing the in-home health assessments required by MedXM.

37. New York Education Law § 6901(1) distinguishes the type of diagnostic privilege that NPs can engage in as distinct from making medical diagnoses. Under New York Education Law § 6902(3), a NP can diagnose illnesses if it is within a specialty area of practice pursuant to a written practice agreement with a collaborating physician who is also qualified within that speciality area. These restrictions prohibited most, if not all, of the diagnoses rendered by New York-based NPs on MedXM health assessment reports because the NPs did not have the relevant specialty practice areas allowing them to diagnose illness as reported by the health assessment reports. Further, New York Education Law § 6542 requires the supervising physician to assign the work to the PA and to provide continuous supervision. Yet, MedXM contracted and assigned work directly to New York-based PAs who then conducted health assessments in violation of these assignment and supervision requirements.

38. *California Business & Professions Code* §§ 2725 and 2835.7 allow NPs to make "Observations of the signs and symptoms of illness" but do not permit NPs to make the complex medical diagnoses required by the health assessments. In California, NPs are not allowed to perform the health assessments unless there are comprehensive written standardized procedures to allow this activity by a clinic, health plan or medical office and such activity is well supervised in accordance with written protocols. *California Business & Professions Code* § 2835.7. Yet, none of the MedXM California NPs worked out of clinics, medical offices or

health systems, and were not rendering services pursuant to agreed upon standardized protocols regarding the health assessments performed for MedXM. Further, California PAs are required to have all of their work supervised by a physician or surgeon who must countersign at least 5% of the medical charts and records. *California Business & Professions Code* § 3502. Yet, MedXM contracted directly with California based PAs in violation of their supervision and documentation requirements.

39. As of at least 2012, the states of California, Nebraska, South Dakota, Kansas, Wisconsin, Missouri, Minnesota, Ohio, Indiana, Illinois, Pennsylvania, New York, Delaware, Virginia, South Carolina, North Carolina Georgia, Florida, Louisiana and Texas had licensure laws restricting the activities of NPs by requiring a licensed physician to supervise and control all work performed.

40. The NPs, including but not limited to the following, performed Health assessments without being under the direction and control of a supervising physician as required by the state laws where the services were performed:

i. California: Alda O'Conner, Carina Viscona-Pons, Catherine Cusi, Christian Eggleston, Colette Spencer, Doreen Urban, Janice Cahambing, Jason Speaks, Jayson Hoppe, Jennifer Pack, Jennie Yeh, Joanna Yoa, Joshua Yi, Julie DePetro, Lillian Harris, Lola Aldrige, Martha Ibarra, Michael Jingo, Patrice Daniels, Patricia Lee, Rick Michel, Sharon Jack, Teresa Magana, Tiffany Johnson, and Viraseni Wu.

ii. New York: Barbra Cohen, Brenda St. Louis, Camellia Corrica, Caryn Moeller, Chaya Wald, Delores McLeod, Denine Polen, Jean O'Doherty, Jiji George, Karen Chung, Lisa Marie Horne, Lorraine Marshall-Williams, Natasha HarrisRavella Jainarain, Salwa Khouri, Svetlana Sakirsky, Tamara Desvarieux, and Vivian Barber.

iii. Texas: Brandy Evans, Hawa Stinson, and Munachi Okpala.

41. Discovery may reveal the identity of additional NPs who performed illegal Health assessments for MedXM because their services were not supervised by a licensed

physician as required by the state laws where the NPs performed such services.

42. NPs, including but not limited to the following, provided MedXM the identity of a supervising physician but such arrangements were a sham and the NPs' Health assessments were not supervised by a licensed physician in violation of the state laws were the NPs performed such services:

i. Ohio: Arthur Myers, Augusta Boyd, Ashley Simela, Crystal Burke, Kaththryn Koebbe, Linda Kibot, Maureen Kilrain, Melanie Nosan, Melissa Fourmann, Misty Uhi, Monique Howard, Pamela Crider, Raja Shaheen, Rhonda Casey, Robin Sloane, Sandra Smith, Scott Rawlings, Sean Haig, Sharon Noffsinger, Stacey Mathews, Susan Quirk, and Tanya McKnight-Tuffour.

43. Discovery may reveal the identity of additional NPs who performed illegal Health assessments by falsely claiming supervision of a licensed physician.

44. All states require that PAs' work is performed under the direction and supervision of a licensed physician. MedXM's PAs, including but not limited to the following, performed MedXM Health assessments without being under the direction and control of a licensed supervising physician: Vadim Troshkin, California; Devin Kaplan, New York; and Tyler Shenk-Foley, New York. Additional discovery will reveal the identities of additional PAs who illegally performed Health assessments on behalf of MedXM or who are misidentified by MedXM as NPs.

45. At all times relevant, MedXM either knew that such NPs and PAs were performing Health assessments without being supervised by a licensed physician as required by CMS regulations, federal law and state law license requirements or turned a blind eye to the true facts regarding compliance with this requirement. Likewise, the defendant Health Plans knew or should have known the same, because federal law requires the defendant Health Plans either approve MedXM's medical examiners or regularly audit such data on an ongoing basis. (*See,* 42 C.F.R. § 422.504(i)(4)(B).)

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Fraudulently Performed Health Assessments

46. The MedXM coders and medical examiners used the enrollees' prior HCC diagnoses provided by the defendant Health Plans and/or the enrollees' medical history obtained by the MedXM medical examiners from the enrollees as the basis to report HCC diagnoses in the health assessment reports. If not already accomplished by the medical examiners, the coders insisted, after the medical examiners had submitted their reports to the coders, on adding additional diagnoses based on the enrollees' prior HCC diagnoses provided by the defendant Health Plans. In many instances, the medical examiners could not make the complex diagnoses that the coders insisted upon based solely upon the patients' past medical history because the medical examiners did not have access to the patients' medical records nor properly performed laboratory and diagnostic test results to confirm such diagnoses.

47. Absent this information, the medical examiners would have to be able to perform a diagnostic tests to confirm many complex diagnoses that were falsely included in the final health assessment reports. However, the MedXM medical examiners did not have a portable EKG machine which is necessary to correctly diagnose atherosclerosis of the coronary arteries and other types of heart disease. Most MedXM medical examiners did not have a portable device to perform spirometry (a physical test needed to diagnose COPD), and this device was not provided to them by MedXM to confirm diagnoses of COPD. The MedXM medical examiners likewise did not have portable x-ray machines and did not perform any invasive investigative procedures such as colonoscopies and sigmoidoscopies.

48. Further, MedMX policy forbade its medical examiners from having the enrollees disrobe during the examination. Besides the obvious fact that clothing prevents the medical examiner from observing malformed limbs, swelling, rashes, discoloration or lesions in the clothed areas, the clothing impairs the examination of the thorax because such clothing make sounds and/or muffle sounds when using a stethoscope. Accordingly, clothing interferes with carefully hearing heart and lung sounds and may prevent the medical examiner from correctly hearing the rales, rubs, ronchi or wheezing (key heart and lung diagnostic sounds) required to make correct diagnoses, such atrial fibrillation, cardiac enlargement, congestive heart failure,

COPD and heart valve defects. In absence of EKG, spirometry testing, radiology, proper blood testing, and the use of other technology (all of which were not utilized by MedXM medical examiners), many of the diagnoses by MedXM medical examiners were unsupported by their examinations.

49. Despite these deficiencies, MedXM medical examiners falsely and improperly confirmed such complex diagnoses, including but not limited to septicemia, metastatic cancers, leukemia, lung cancer, digestive track cancer, breast cancer, prostate cancers and tumors, ophthalmological manifestations of diabetes, end stage liver disease, cirrhosis of liver, chronic hepatitis, intestinal obstructions or perforation, pancreatic disease, inflammatory bowel disease, infections of the bone, joint or muscle, hematological disorders, immunity disorders, polyneuropathy, multiple sclerosis, acute myocardial infarction, unstable angina and other ischemic heart disease, angina pectoris, old myocardial infarction, specified heart arrhythmias, cerebral hemorrhage, ischemic or unspecified stroke, cystic fibrosis, bacterial pneumonia, pneumococcal pneumonia lung abscess, proliferative diabetic retinopathy, and vertebral fractures without spinal cord injury. These above listed diagnoses were not possible for MedXM's medical examiners to confirm during the in-home health assessments because confirmation required an additional blood test that had not been ordered as part of the health assessments (and the medical examiners were not authorized to order additional blood tests at their discretion) and/or an x-ray, MRI, EKG, biopsy or some other invasive procedure that was not, and could not be, performed by the MedXM medical examiners. In some cases, confirmation required an additional follow-up visit and/or the diagnosis to be made by a specialist, such as an ophthalmologist, oncologist or cardiologist, while in other situations a confirming diagnosis was not possible without the medical examiner being able to confirm a prior diagnosis in the patient's medical records (which MedXM's medical examiners did not have access to) performed by the patient's primary care physician or a specialist physician. These false and improperly confirmed diagnoses inflated the MA enrollees' risk adjustment scores, resulting in CMS paying higher capitation payments to the defendant Health Plans.

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Examinations Not Performed In Person

50. RAD must be the result of a face-to-face encounter with a medical examiner.[16] During the first quarter of each calendar year, MedXM performed few if any health assessments for MAOs. For the balance of the year, each contracted medical examiner was assigned an average of 8-12 in-home health assessments per day. However, MedXM scheduled 20 to 25 in-home health assessments per day for several key medical examiners who requested to perform high volumes of assessments. Such a high volume of daily in-home face-to-face assessments could not have occurred because of the time required to perform an examination and travel from each patient's home to the next, and the MAO's requirements that the assessments could only be performed during an window of no more than 11 hours per day. As is explained in detail below, MedXM routinely submitted health assessment reports and resulting invalid RAD to the defendant Health Plans that were not the result of face-to-face visits in violation of CMS regulations. In turn, the Health Plans submitted the invalid RAD to CMS to increase their capitated payments from CMS.

51. MedXM's unwritten policy and practice was to reward medical examiners who were willing to participate in MedXM's fraudulent scheme of converting MA enrollees' past medical history and diagnoses into current HCC diagnoses by allowing such participating medical examiners to perform as many health assessments per day as they wanted. The financial inducement was significant as medical examiners were paid on average $100 per health assessment with the range being between $80 and $125. If a medical examiner performed between 20 to 25 assessments per day, s/he could earn between $40,000-$60,000 per month without any office overhead expense.

52. At all times relevant, MedXM and the defendant Health Plans knew that a MedXM in-home health assessment encounter took about 45 minutes. Given the 11 hour window to perform in-home health assessments, the 45 minutes needed to perform the in-home health assessment, and the time to travel from one MA enrollee's home to the next, it is

[16]CMS Medicare Managed Care Manual, Ch. 7, § 40 ["All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit."].

impossible for a MedXM medical examiner to perform more than 13 in-home health assessments a day.

53. MedXM medical examiners, including but not limited to the following, were consistently scheduled high visit volumes (in excess of 15 in-home visits per day) despite MedXM's knowledge that these examiners failed to comply with the face-to-face encounter requirement and/or submitted false and fraudulent data:

i. Dr. Muhammad Awaisi, Michigan, scheduled 20-25 patients per day;

ii. Dr. Jeffry Kashuk, New York, scheduled 20-25 patients per day;

iii. Cindy Sprau, NP, Ohio, scheduled 20-25 patients per day;

iv. Dr. Mark Christopher, Ohio, scheduled 15-20 patients per day;

v. Dr. Robinson, scheduled 20-25 patients per day; and

vi. Vadim Trsoshkin, California, scheduled 15-17 patients per day.

54. During or about December 2012, Molina noticed that MedXM medical examination reports for a number of Molina patients had identical vital statistics for age, weight, sex, height, blood pressure, and heart rate, and notified MedXM. All of the patients involved had health assessments purportedly performed by the MedXM's Dr. Awaisi. MedXM determined that Dr. Awaisi did not actually examine all of these patients as some were seen by his medical assistant who was not credentialed with MedXM nor approved by Molina. Further, Dr. Awaisi routinely purportedly completed more than 22-25 assessments per day for Molina traveling over a wide geographic area making it highly implausible that he actually performed the work that he claimed.

55. Upon finding out about Dr. Awaisi's duplicate records relating to the patient assessments, MedXM's COO instructed MedXM's scheduling department staff to telephonically call Dr. Awaisi's MA examinees and interview them under the pretense of performing quality improvement. Through these telephonic interviews, MedXM learned that Dr. Awaisi was not performing all of the visits as he claimed, but that his medical assistant was performing a significant number of them in violation of CMS guidelines. MedXM then had the patients reveal over the telephone their age, height, weight and normal blood-pressure,

as well as any other relevant medical information, and plotted it on a spreadsheet. This information was forwarded to Dr. Awaisi so he could redo the health assessment reports. Dr Awaisi took the information from the spreadsheets and created new health assessment reports based on the information provided. MedXM provided the altered health assessment reports to Molina.

56. MedXM's CEO misrepresented to Molina that a printer malfunction caused the data to duplicate the vital statistics, notes and findings on the various health assessment reports previously sent to Molina. Molina accepted this implausible explanation and the resubmitted assessment reports without further question, and submitted to CMS the RAD arising from the resubmitted health assessment reports.

57. The resubmitted health assessment reports were fraudulent because they were not based upon face-to-face examinations by Dr. Awaisi, but rather based upon information provided by the patients to MedXM over the telephone, and included findings that Dr. Awaisi fabricated.

58. MedXM's investigation of Dr. Awaisi's failure to perform face-to-face encounters only went back 60 days, and did not address his encounters prior to then. Although this cursory investigation confirmed that Dr. Awaisi had his medical assistant perform many of the in-home examinations without him being present and that Dr. Awaisi was fabricating diagnoses and medical findings, MedXM failed and refused to undertake a comprehensive investigation of the Medicare fraud problem, failed and refused to review Dr. Awaisi's health assessment reports more than 60 days old, failed and refused to undertake any corrective action regarding the frauds they discovered, and proceeded to knowingly submit or caused to be submitted false and fraudulent RAD to CMS.

59. During or about January 2013, Relator recommended to MedXM's CEO, COO and Vice President of Operations that Dr. Awaisi be immediately terminated, MedXM disclose to Molina the problem created by Dr. Alwasi, MedXM retrieve and withdraw Dr. Alwasi's assessment reports and create a Corrective Action Plan that included the hiring of a Quality Assurance Director to prevent a repeat of the problem. However, Relator's recommendations

were ignored, and Dr. Awaisi still actively performs health assessments and other assessment services for MedXM on Molina Medicare and Medicaid enrollees. MedXM's CEO advised Relator that Dr. Awaisi's services were needed because of his high volume and willingness to travel. Relator further complained to MedXM's CEO and COO that MedXM was committing Medicare fraud because Dr. Alwasi's health assessment reports were not the result of face-to-face examinations.

60. During March 2013, a similar problem arose with Dr. Robinson's health examination reports of Molina patients. MedXM coders noticed that approximately 350 of Dr. Robinson's initial assessment reports had the identical information for the patients' physical examination reports. MedXM's senior management failed and refused to undertake any type of investigation to determine the extent of Dr. Robinson's activities and frauds, or to determine which Health assessment reports were not the result of face-to-face encounters. Rather, MedXM had Dr. Robinson collaborate with MedXM's coding trainer, Brian Hazel, to help her revise her assessment reports so that they did not have identical information. These improperly modified assessment reports were then submitted to Molina, and then on to CMS. During or about March 2013, Relator recommended to MedXM's CEO and COO that Dr. Robinson be terminated and retrieve and withdraw her health assessment reports. However, Relator's recommendations were ignored, and Dr. Robinson was not immediately terminated because of her willingness to travel great distances to perform health assessments and her relationship with Molina, who had requested that MedXM hire Dr. Robinson to perform health assessments on its Medicare enrollees. Relator advised MedXM's CEO and COO that MedXM was committing Medicare fraud because Dr. Robinson's assessment reports were not the result of face-to-face examinations.

61. The health assessment reports provided by Dr. Robinson were fraudulent because the physician's findings and physical examinations were fabricated in collaboration with MedXM's coder and were not the result of the physician's observations during face-to-face encounters. MedXM failed to initiate a proper investigation although it was aware of the fraud, failed to take any corrective action and knowingly submitted or caused to be submitted

false and fraudulent RAD to CMS.

62. Vadim Troshkin, a MedXM medical examiner in the San Diego area, improperly obtained medical information from numerous patients by telephone, instead of obtaining such information from in person visits, and fraudulently completed medical examination reports as if such information was obtained during in visit examinations.

63. During or about December 2011, a MA enrollee, who received an in-home health assessment examination from Troshkin, called MedXM to complain that he conducted the entire examination over the telephone. When questioned by MedXM senior management, Troshkin readily admitted to conducting a telephonic examination practice. Based on Troshkin's disclosures, MedXM knew that Troshkin's health assessment reports that were not the product of face-to-face encounters resulted in a fraudulent submission of RAD to CMS. MedXM failed and refused to perform an investigation to determine the extent or magnitude of the fraud despite CMS regulations and guidelines to the contrary. (Medicare Managed Care Manual, Ch. 7, § 40.) Further, MedXM failed and refused to initiate a corrective action plan or to withdraw Troshkin's health assessment reports and resulting RAD from Wellpoint and Health Net. Instead, MedXM continued to knowingly submit Troshkin's fraudulent health assessment reports and resulting RAD to the enrollee's health plans and ultimately to CMS.

64. During or about December 2011, Relator complained to MedXM's CEO that Troshkin should be immediately terminated, and that Troshkin's health assessment reports submitted to MAOs, including but not limited to the defendant Health Plans, be withdrawn. Relator is informed and believes that MedXM refused to promptly comply with these recommendations.

Submission of False Blood Test Results

65. MedXM routinely and knowingly generated false RAD based in whole or in part upon laboratory blood test results that it knew were unreliable.

66. In order to properly preserve blood test samples, such samples must be spun down in a centrifuge to separate the plasma from the red blood cells and then refrigerated. MedXM did not provide its medical examiners with either a portable centrifuge nor portable

coolers to adequately preserve the blood samples.

67. MedXM's medical examiners delivered the blood test samples at a collection station for the defendant Health Plans' contracted labs. Typically, the medical examiners' last health assessment examination was after the such collection stations closed so the unprocessed blood samples remained in the medical examiners' vehicles until the next day. This process caused the blood test samples to spoil and made the blood test results unreliable.

68. During the latter half of 2012, Relator was informed by representatives from LabCorp and Quest Diagnostics (the two primary laboratories used by the defendant Health Plans) that the blood samples that MedXM medical examiners submitted were spoiled because the blood samples had not been promptly spun down in a centrifuge nor properly stored by MedXM medical examiners. The laboratory representatives informed Relator that the spoilage caused the test values to be higher and also caused a high number of critically high test values. Relator reported this information to MedXM's CEO and COO during or about the latter half of 2012. The blood spoilage issue was common knowledge at MedXM.

69. The labs returned the test results of the spoiled blood samples to the MedXM medical examiners who originally requested them. These results were included as part of the health assessment reports despite the fact that MedXM knew the results were unreliable due to the spoilage of the blood samples.

70. When critically high test values (suggesting the patient's life was in danger) were generated from the spoiled blood samples, the labs placed telephone calls to MedXM's CEO to ensure that MedXM was aware of the unusual result and could take appropriate action. However, MedXM did not repeat the blood tests with blood samples that were not spoiled with regards to the critically high test results.

71. During Relator's employment with MedXM, MedXM made no effort to address or improve the preservation of the blood samples. MedXM did not inform the defendant Health Plans, who were paying the cost of the lab tests, that MedXM was knowingly processing and reporting results from spoiled blood samples and that such results were not reliable.

72. Throughout Relator's employment with MedXM, the spoiled blood samples were used to make false diagnoses of, among other things, chronic kidney disease, anemia and leukemia, confirmation of vascular disease, heart disease and higher risk of stroke (from tests on cholesterol and triglyceride levels), and the severity of diabetes in type II patients, among other HCC diagnoses.

Other Frauds

73. At all times relevant, MedXM knew that its medical examiners, Dr. Hanna Rhee, and NP Ron Bedford, were licensed in California, but not in Oregon. However, MedXM assigned Dr. Rhee and Mr. Bedford to conduct medical examinations of Health Net patients in Oregon in spite of knowing through background investigations that they were not licensed practice medicine or perform services in that state. Dr. Rhee conducted examinations of such patients in Oregon during or about Fall 2011, and prepared medical evaluations thereon which were submitted to MedXM, and then forwarded to Health Net. Mr. Bedford conducted examinations of such patients in Oregon during or about Fall and Winter 2011, and prepared medical evaluations thereon which were submitted to MedXM, and then forwarded to Health Net. Such evaluation reports did not comply with CMS regulations because Dr. Rhee and Mr. Bedford was not licensed to practice in Oregon. During or about 2012, Relator advised MedXM's CEO and COO that Dr. Rhee was performing assessments in Oregon for which she was not licensed. However, MedXM's CEO advised Relator that MedXM sent Dr. Rhee to Oregon because she was willing to travel, and took no corrective action.

Damages Caused by MedXM's Misconduct

74. 42 C.F.R. § 422.504(l)(3) requires MedXM to periodically certify as to the accuracy, completeness, and truthfulness of the RAD it submitted to its MAO clients, including the defendant Health Plans. Relator is informed and believes that MedXM made at least one such express certification. Such express certifications, if made, were false. Further, by submitting RAD to the defendant Health Plans, knowing that such RAD would be submitted to CMS, MedXM impliedly certified that its submitted RAD was accurate, complete and truthful under 42 C.F.R. § 422.504(l)(3).

75. MedXM's express and/or implied certifications were false. MedXM conduct ed a noncompliant and fraudulent practice of behavior that included, but is not limited to (a) knowingly submitting health assessment reports to the defendant Health Plans that failed to contain a valid authenticating signature from the medical examiners, (b) knowingly failing to use and maintain EHR documentation practices in accordance with CMS requirements, (c) knowingly allowing MedXM NPs and PAs to perform health assessments and make medical diagnoses outside the scope of their license which resulted in the submission of false RAD sent to the defendant Health Plans, and in turn to CMS, (d) training MedXM's coders to coach MedXM medical examiners to make improper, false and fraudulent medical diagnoses on the health assessment reports that resulted in the submission of false RAD to the defendant Health Plans, and in turn to CMS, (e) knowingly submitting RAD and health assessment reports to the defendant Health Plans based upon health assessments that were not the result of face-to-face encounters, and (f) assisting MedXM medical examiners to fabricate, out of whole cloth, false and fraudulent clinical findings and medical diagnoses for inclusion in health assessment reports that resulted in the submission of false RAD to defendant Health Plans, and in turn to CMS. MedXM's noncompliant and/or fraudulent conduct prevented MedXM from making valid attestations pursuant to 42 C.F.R. §422.504(l)(3).

76. Correspondingly, MedXM's MAO clients, including the defendant Health Plans, submitted invalid RAD to CMS based on MedXM's improperly performed health assessments and false and fraudulent HCC diagnoses codes, resulting in the Government paying excessive payments to MedXM's MAO clients, including the defendant Health Plans, as a result of HCC risk adjustment scores that were procured through fraudulent, non-compliant MedXM heath assessments, reports and processes.

The Defendant Health Plans' Fraudulent Scheme

77. The defendant Health Plans retained MedXM's in-home health assessment services with the intent to maintain or increase CMS' capitated payments to the defendant Health Plans by having MedXM prepare health assessment reports and obtain diagnoses of MA enrollees who had no medical encounters that year and/or the prior year. In an effort to

maximize their profits from utilizing MedXM's services, the defendant Health Plans provided MedXM with their MA enrollees' prior HCC diagnoses, and kept track of the MedXM assessment reports that resulted in diagnosis codes that were the same as the prior HCC diagnoses submitted to MedXM. Further, each defendant Health Plan either knew or acted in reckless disregard of truth that (a) MedXM's health assessment reports in support of the MedXM RAD that each of the defendant Health Plans submitted to CMS did not have a valid authenticating signature by the medical examiners as required by CMS, (b) MedXM's EHR practices failed to preserve and identify all entries and changes to the health assessment reports as required by well established national standards (AHIMA) and codified by CMS,[17] (c) MedXM contracted with NPs without validating that such NPs were practicing within the scope of their license,[18] (d) the defendant Health Plans accepted health assessment reports prepared by MedXM NPs that were practicing outside the scope of their license,[19] (e) the defendant Health Plans accepted MedXM health assessment reports prepared by MedXM PAs that contracted directly with MedXM in violation of such PAs' scope of licensure,[20] (f) the defendant Health Plans accepted health assessment reports prepared by MedXM PAs who were not working under the direct supervision of a physician as required by CMS requirements and therefore outside the scope of their licensure,[21] (g) the defendant Health Plans did not properly investigate, monitor and oversee the delegation to MedXM of credentialing of MedXM medical examiners required by federal law and CMS requirements,[22] (h) the defendant Health Plans did not properly investigate, monitor and oversee MedXM's

[17]AHIMA 2009, Amendments, Corrections and Deletions in the Electronic Health Record: Toolkit, pp. 1-8; Medicare Program Integrity Manual, Ch. 3, § 3.3.2.5.

[18]42 C.F.R. §§ 422.204, 422.504(a)(6) and (i).

[19]42 U.S.C. § 1395x(aa)(5)(A) and (6); 42 C.F.R. §§ 410.75, 422.504(l)(2).

[20]42 U.S.C. § 1395x(aa)(5)(A); 42 C.F.R. §§ 410.74, 422.504(l)(2).

[21]42 U.S.C. § 1395x(aa)(5)(A) and (6); 42 C.F.R. §§ 410.75, 422.504(l)(2).

[22]42 C.F.R. §§422.204, 422.504(i); Medicare Managed Care Manual, Ch. 6, § 60.3.

complaince with HIPAA training and security requirements as required by federal law,[23] [24] (i) the defendant Health Plans accepted MedXM's health assessment reports, encounter data and RAD knowing that they contained false and fraudulent HCC diagnosis codes and submitted same to CMS in violation of federal law,[25] (j) the defendant Health Plans failed to implement an effective compliance program with regards to MedXM to identify and ameliorate Medicare fraud, waste and abuse ("FWA") as required by federal law,[26] [27] (k) the defendant Health Plans knowingly accepted MedXM health assessment reports and RAD that was not the result of face-to-face encounters in violations of CMS regulations,[28] and (l) the defendant Health Plans falsely certified the RAD originating from MedXM was truthful, accurate and complete to its best knowledge and belief without having any basis for such a belief.[29] The defendant Health Plans' violations described in (a)-(l) above resulted in either a factually false claim, a legally false claim or is evidence of their scienter to submit a false claims to the Government.

78. The MedXM health assessments performed on behalf of the defendant Health Plans (which formed the basis of the RAD MedXM submitted to the defendant Health Plans, who in turn submitted such RAD to CMS) did not have valid signatures in accordance with CMS regulations. As a result, the RAD from such health assessment reports were not supported by properly documented medical records (i.e., health assessment forms), and thus should not have been submitted by or on behalf of the defendant Health Plans to CMS to risk adjust CMS' capitated payments tot he defendant Health Plans for the MA enrollees that were

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[23] 45 C.F.R. §§ 160, 162 & 164, 422.504(h)-(i).

[24] Had the defendant Health Plans done so, they would have detected MedXM's fraudulent conduct.

[25] 42 C.F.R. §422.504(h)-(l)(2)-(3).

[26] 42 C.F.R. § 422.503(b)(4)(iv).

[27] Had the defendant Health Plans done so, they would have detected MedXM's fraudulent conduct.

[28] Medicare Managed Care Manual, Ch.7, § 40.

[29] 42 C.F.R. § 422.504(l)(2).

the subject of such health assessment reports. At all times relevant, MedXM knew or should have known that the submission of RAD arising from MedXM health assessment reports to the defendant Health Plans and/or CMS was not permitted because MedXM's health assessment reports bore only the typewritten names of the MedXM medical examiners and did not bear required actual or digitally encrypted signatures of the MedXM medical examiners.

79. During and between 2010 and 2014, MedXM sent its health assessment reports to the defendant Health Plans. All of the MedXM health assessment reports only bore the medical examiner's typewritten name, and not a signature permitted by CMS. Because the defendant Health Plans had the MedXM health assessment reports in their possession, the defendant Health Plans knew that the MedXM health assessment reports were not properly documented medical records because they only bore the typewritten names of MedXM medical examiners and did not bear handwritten signatures or valid electronic signatures of MedXM medical examiners. The defendant Health Plans knew that the MedXM health assessment reports did not bear digitally encrypted signatures because the typewritten names of the medical examiners did not bear telltale indicators indicating that such typewritten names were authentic and digitally encrypted signatures. Similarly, the signatures did not purport to be valid electronic signatures because they did not contain statements such as "Electronically signed by," "Authenticated by," "Sealed by," "Data entered by," "Approved by," "Verified by," etc., that would accompany a valid electronic signature. Nonetheless, the defendant Health Plans submitted MedXM's RAD to CMS even though the defendant Health Plans knew that such RAD was not supported by properly documented health assessments.

80. At all times relevant, 42 C.F.R. § 422.504(l)(2) required the defendant Health Plans to have the CEO or someone acting on the CEO's behalf, certify to CMS that all of the RAD that each defendant Health Plan submitted to CMS during the course of a calender year was accurate, truthful and complete to their best knowledge and belief. Compliance with this certification requirement is expressly stated as a condition of receiving the defendant Health Plans' monthly capitation payments. Similarly, 42 C.F.R. § 422.504(l)(3) requires the defendant Health Plans to obtain a certification from any first tier entity, such as MedXM, who

is the source of any RAD that the defendant Health Plan submits to CMS. Relator is informed and believes that the defendant Health Plans submitted their 42 C.F.R. § 422.504(l)(2) certifications to CMS for each of the years in question.

81. None of the defendant Health Plans required MedXM to implement an effective compliance program. During and between 2009 to at least the end of Silingo's employment, MedXM failed to implement an effective compliance program.[30] Prior to 2009, MedXM had not performed any health assessments or health assessments reports of MA enrollees. Other than performing health assessments for MA enrollees beginning in 2009, MedXM had never provided any health care services to Medicare beneficiaries nor MA enrollees. MedXM was not familiar with and did not know how to comply with CMS' complex requirements for proper medical examiner credentialing, EHR documentation and authentication, correct coding practices consistent with ICD-9 and AHIMA coding guidelines and conventions, NP and PA collaboration and supervision requirements, and HIPAA requirements to safeguard confidential patient health information and CMS' requirements to prevent Medicare FWA. Because of MedXM's lack of prior experience as a Medicare provider, lack of an effective compliance program and actual lack of compliance with CMS requirements and federal law as described above, the defendant Health Plans' acceptance of MedXM's express or implied certifications under 42 C.F.R § 422.504(l)(3) was with reckless disregard and with deliberate ignorance of the truth. The true facts were that any certification concerning the accuracy, truthfulness and completeness of RAD generated by MedXM concerning data generated during and between 2009 to 2013 was false.

82. Similarly, none of the defendant health plans implemented an effective compliance program with regards their contracts with MedXM to have to MedXM perform health assessments of the defendant Health Plans' MA enrollees and to submit to the defendant

[30]See, 42 C.F.R. §§ 422.503(b)(4)(iv), 422.504(i)(3)(iii) and 4(v); Medicare Managed Care Manual, Ch. 21 §§30-50.

Health Plans health assessment reports, encounter data and RAD that originated therefrom.[31] An effective compliance would include, among other things, routine monitoring of MedXM's compliance with the terms and conditions of the defendant Health Plan's contract with CMS, federal laws and CMS requirements. Had the defendant Health Plans implemented and maintained an effective compliance program with regards to their contracts with MedXM, the defendant Health Plans would have discovered, among other things, that MedXM was using Microsoft Word and medical examiner's personal e-mail accounts, instead of an appropriate EHR software package and a secure e-mail server, to have MedXM's medical examiners prepare the health assessments reports and transmit the health reports assessments to MedXM. The knowledge that MedXM was using Microsoft Word and non-secured e-mail systems should have informed the defendant Health Plan that (a) MedXM did not have a policy for and was not creating valid electronic or digitally encrypted signatures for MedXM's medical examiners to authenticate the health assessments reports, (b) MedXM did not follow AHIMA and CMS EHR documentation requirements regarding amendments and alterations to the health assessment reports because MedXM's medical examiners and coders were using unlocked documents instead of a compliant EHR system, and (c) MedXM's computer hardware and software systems were not HIPAA-compliant because, among other things, MedXM was using its medical examiners' personal e-mail accounts to transmit and receive confidential patient health information. Additionally, a compliance program's oversight function would have alerted the defendant Health Plan that: (1) MedXM was not validating that its NPs and PAs were practicing within the scope of their license as part of MedXM's credentialing process as required by contract and CMS requirements,[32] and (2) MedXM NPs and PAs were not performing health assessments and documenting the health assessment reports within the scope of their licensure because MedXM's NPs and PAs were not working under state law collaboration and supervision requirements, were not working under federal

[31] *See*, 42 C.F.R. §§ 422.503(b)(4)(iv), 422.504(i); Medicare Managed Care Manual, Ch. 21 §§30-50.

[32] *See*, 42 C.F.R. §§422.204(a),(b)(2)(i) and (3), 422.504(a)(6) and (i)(4)(iv)-(v); Medicare Managed Care Manual, Ch. 6, §60.3.

collaboration and requirements when applicable, and PAs directly contracted with MedXM and were not working under the direct supervision and control of a licensed physician.[33]

85. Because none of the defendant Health Plans (a) implemented an effective compliance program with regards to their contracts with MedXM, (b) required MedXM to implement its own effective compliance program, and (c) performed routine monitoring and oversight to ensure that MedXM complied with CMS requirements to detect and ameliorate Medicare FWA, there was no good faith basis for making (or maintaining) a certification pursuant to 42 C.F.R. §422.504(l)(2) as to the RAD the defendant Health Plans submitted to CMS that originated from MedXM. The defendant Health Plans' failure to attempt to discover and remedy MedXM's fraudulent acts described above, bar the defendant Health Plans' CEO (or its designee) from certifying claiming that RAD originating from MedXM was accurate, truthful and complete to the best of his/her knowledge and beleif. Had a modest effort been made to require MedXM to comply with the defendant Health Plans' terms and conditions of their contracts with CMS, MedXM's numerous frauds and illegal behavior described above, would have come to light.

83. At all times relevant, 42 C.F.R. § 422.503 required the defendant Health Plans to have in place an effective compliance program that met CMS' requirements to prevent, detect, and correct non-compliance with CMS' program requirements, as well as prevent, detect, and correct fraud waste and abuse. This comprehensive legislation is the centerpiece of CMS' enforcement and regulation of MAOs with respect to the detection of fraud, waste and abuse, and has been a mandatory requirement since 2010. (Fed.Reg., Vol. 75, No. 72 19678 at 1809-10, (April 15, 2010).) The original legislation defined the elements of an effective compliance program, and created an affirmative duty on each MAO (including its senior management and governing body) to be knowledgeable about compliance requirements and to ensure that the compliance plan is properly implemented, and accomplishing its objectives. (See, 42 C.F.R. § 422.503(b)(4)(iv).) Effective January 2013, CMS added Chapter

[33] *See*, 42 C.F.R. §§ 410.74(a)(iv)-(v), 410.75(b) and (c)(3)(i)-(ii), made applicable to Medicare Advantage by 42 C.F.R. §§ 422.101(b)(2) and 422.204(b)(2)(i).

21 to the Medicare Managed Care Manual, which sets forth more detailed and comprehensive requirements for an effective compliance program, including but not limited to requiring MAOs, including the defendant Health Plans, to perform a risk assessment to identify those activities that pose a higher risk of Medicare FWA, establish a work plan to address internal and external monitoring and oversight, and requires the routine monitoring of MAOs' first tier entities, such as MedXM, to ensure that such first tier entities are in compliance with federal laws and CMS requirements. (*See*, Medicare Managed Care Manual, Ch. 21, §§ 30-50.)

84. The minimum basic requirements include, but are not limited to, written comprehensive effective compliance program policies and procedures to prevent, detect, and correct fraud, waste, abuse and non-compliance with CMS's program requirements that are well publicized throughout the organization, ongoing programs of risk assessment, self evaluations and audits designed to validate the compliance program and discover fraud, waste and abuse through and timely investigations of all compliance issues related to payment, regular (at least annually) compliance education of senior management, governing body, and first tier, downstream and related (FDR) entities, regular reports to the MAO's governing body regarding compliance efforts, effective lines of communication for reporting of compliance issues from MAO employees as well as from FDRs, and non-intimidation policies protecting employees from reporting and/or resolving compliance issues. (*See*, Medicare Managed Care Manual, Ch. 21 §§ 30-50.)

85. In discussing the Medicare Advantage health plans' requirement to certify the accuracy of risk adjustment data and new requirement imposing FCA liability for the retention of overpayments set forth at 42 C.F.R. §§ 422.504(l) and 422.326, CMS stated, "[F]or many years organizations have been obligated to submit accurate, complete and truthful payment related data, as described §422.504(l).... Further, CMS has required for many years that diagnoses that MA organizations submit for payment be supported by medical record documentation. Thus we have always expected that MA organizations or Part D sponsor implement, during the routine course of business, appropriate payment evaluation procedures in order to meet the requirements of certifying the data they submit to CMS for purposes of

payment. Therefore we do not believe that §422.326 ... represent such a new requirement." 79 Fed. Reg. 29844, 29923 (May 23, 2014). CMS further explained, "MA organizations ... are expected to have effective and appropriate payment evaluation procedures and effective compliance programs as a way to avoid receiving or retaining overpayments. Thus, at a minimum, reasonable diligence would include proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments. However, conducting proactive compliance activities does not mean that the person has satisfied the reasonable diligence standard in all circumstances. In certain circumstances, for example, reasonable diligence might require an investigation conducted in good faith and in a timely manner by qualified individuals in response to credible information of a potential overpayment." *Id.*

86. A MAO's duty to validate risk data does not stop at the MAO's doors but extends to all of the MAO's FDR entities the MAO contracts with (a first tier entity is one having a direct contract with a MAO for the provision of covered benefits under the MAO's Medicare Advantage contract). MedXM is a first tier contracting entity of each defendant Health Plan. The MAOs are required to ensure that their first tier contracted entities are also in compliance with all of the regulations and laws affecting the MAOs and their requirements under their Medicare Advantage contracts. 42 C.F.R. §§ 422.504(i), (l)(3); 422.503(b)(4)(iv)(C)(1)-(3), (D).

87. In order to comply with duties imposed by 42 C.F.R. §§ 422.503 and 422.504, the defendant Health Plans were required to:

i. Conduct compliance education and training at MedXM;

ii. Validate MedXM's assertions that it had a state of the art computer infrastructure and electronic medical record system;

iii. Ensure that MedXM had a HIPAA-complaint computer infrastructure designed to safeguard confidential patient information in accordance with federal law and appropriate policy and procedures related thereto;

iv. Ensure that MedXM maintained an electronic medical record system

produced a valid electronic signature per CMS signature requirements and that MedXM had appropriate policies and procedures for maintaining the accuracy and integrity of the medical records it created and the data it reported in accordance with federal law and CMS rules, regulations guidelines and standards;

v. Ensure that MedXM had a Compliance Officer, a compliance program and appropriate policies and procedures for the effective implementation of the same in accordance with federal law and CMS regulations and guidelines;

vi. Regularly and actively monitor MedXM's activities and data submissions for incidents of fraud and respond accordingly; and

vii. Promptly investigate and correct any suspected incidences of Medicare fraud.

88. None of the defendant Health Plans, nor any of the other health plans, that contracted with MedXM to provide health assessment reports (except Wellpoint which will be discussed in more detail below) made an attempt of any kind to satisfy the duties set forth hereinabove. Instead, they all turned a blind eye to the truth in exchange for receiving inflated HCC risk assessment data that increased their HCC risk adjustment scores and thereby increased their capitation revenue from CMS. Had the defendant Health Plans made even a modest attempt to certify or validate any of MedXM's claims regarding their coding and documentation policies, signature policies, enrollee/physician scheduling policies, compliance program and related policies, allied health professional credentialing policies and/or computer systems and infrastructure or, if the defendant Health Plans complied with their statutory obligations to maintain an effective compliance program with regards to the MedXM data, the true facts would have become immediately apparent.

89. The true facts are that:

i. MedXM did not have any type of approved electronic medical record software system;

ii. MedXM did not have appropriate policies or procedures for documenting physician chart notes or amendments and changes thereto and did not do so in a manner that complied with acceptable charting standards or CMS guidelines;

iii. MedXM did not have appropriate policies and procedures for having physicians authenticate the medical records and data they submitted to defendant Health Plans and MedXM physicians did not validly authenticate the medical records or data that was submitted to defendant Health Plans;

iv. MedXM did not have an effective compliance program nor policies and procedures to properly train their management and staff regarding fraud, waste and abuse, and MedXM routinely submitted fraudulent and inaccurate data to defendant Health Plans;

v. MedXM did not have appropriate policies and procedures or employee training for HIPAA compliance as required by federal law, CMS guidelines and regulations, and did not properly report HIPAA data breaches when such breaches occurred;

vi. MedXM condoned physicians completing the assessment reports without having a face-to-face encounter as required by federal law and CMS regulations and scheduled an unrealistically high number of daily visits for medical examiners who violated this requirement; and

vii. MedXM did not ensure that contracted NPs and PAs acted under the supervision and control of a physician and/or collaboration with a supervising physician, respectively, in accordance with federal and state laws and further, in instances when documentation of collaboration or supervision was proffered to MedXM, MedXM knew such documentation was bogus and that no actual physician supervision or collaboration occurred.

90. At all times relevant, Wellpoint knew that the MedXM health assessment reports of Wellpoint's MA enrollees did not have valid authenticating signatures. As previously alleged, CMS requires that the information on the health assessment reports be authenticated by an handwritten signature or a valid digitally encrypted or electronic signature. The MedXM health assessment reports only contained typed names of the medical examiners, which is not an acceptable signature method, resulting in the MedXM health assessment not being properly documented, and the resulting RAD invalid. Nonetheless, Wellpoint submitted the MedXM RAD to CMS resulting in factually false claims.

91. Paragraph 49 provides a number of medical conditions that are not possible to make a confirming medical diagnosis of during the MedXM in-home health assessments because confirming such diagnoses requires additional information or testing that were not available to the MedXM medical examiners while performing the health assessments when the health assessment reports were prepared. Silingo is informed and believes and thereupon alleges that many of the medical diagnoses identified in paragraph 49 were included in the MedXM health assessments reports of Wellpoint's MA enrollees. Each of the diagnoses identified in paragraph 49 also corresponds to a HCC diagnosis code, and causes an increase in the assessed MA enrollees risk adjustment score, and therefore caused an increase in the capitation payments that Wellpoint received for that MA enrollee in subsequent periods. As a MAO contracted with CMS, Wellpoint knew that the medical diagnoses identified in paragraph 49 and their related HCC diagnosis codes cannot be confirmed during the health assessments that Wellpoint requested MedXM to perform. Wellpoint's submission to CMS of the RAD originating from the MedXM health assessment reports that contain any of the medical diagnoses and/or their related HCC diagnosis codes identified in paragraph 49 results in factually false claims.

92. Wellpoint knew that MedXM did not document it NPs' scope of licensure as part of MedXM's credentialing process as a result of the four audits Wellpoint performed during 2011 and 2012 and the CAP it issued to MedXM regarding improper NP credentialing. Wellpoint either knew or acted with reckless disregard regarding the accepting RAD from

MedXM NPs who were practicing outside the scope of their license. As part of the Wellpoint's compliance program, it was required to perform a risk assessment to determine areas of its and MedXM's FWA vulnerability. Most states did not allow NPs to make medical diagnoses (required for supporting documentation for HCC diagnoses) as opposed to nursing diagnoses, unless the NPs are working in collaboration with a physician and practicing under standardized practice protocols that provide for the extension of the NPs scope of practice to include making medical diagnoses. These arrangements are typically part of an employment relationship between the NP and healthcare facility or medical clinic, and do not apply for independent contractor work on patients unrelated to that collaborative employment relationship.

93. Wellpoint's submission of RAD supported by health assessments performed by large numbers of independent NPs is a high risk issue for potential FWA. The MedXM NPs were not employees nor supervised by MedXM. Rather, MedXM's NPs were independently contracted to perform health assessments of Wellpoint's MA enrollees. Because most states do not allow independent NPs to make medical diagnoses, the high percentage of NPs used by MedXM should have been a serious red flag of Medicare fraud and raised concerns as part of Wellpoint's compliance program. Accordingly, Wellpoint should have known that MedXM's NPs were in fact practicing outside the scope of their licensure, and in conjunction with MedXM's failure to document that its contracted NPs were working collaboration with a physician, should have triggered a fraud investigation by Wellpoint. Wellpoint did not act and did not enforce its CAP regarding NP credentialing as is discussed below. Rather, Wellpoint acted with reckless disregard for the truth in failing to identify the fraudulent RAD from NPs practicing outside the scope of their licensure because they were not working in collaboration with a licensed physician or under standardized practice guidelines that would extend the scope of their practice to include medical diagnoses. This results in both factually and legally false claims because Wellpoint's certification cannot extend to medical examiners who are outside the scope of their practice.

94. The NPs that performed health assessments of Wellpoint's MA enrollees made

improper medical diagnoses (resulting in invalid RAD and HCC diagnosis codes) outside the scope of their practice because they were not working in collaboration with licensed physicians and/or in compliance with applicable state law licensure restrictions. The Wellpoint-authorized NPs include, but are not limited to:

> Alda O'Conner, Carina Viscona-Pons, Catherine Cusi, Christian Eggleston, Colette Spencer, Doreen Urban, Janice Cahambing, Jason Speaks, Jayson Hoppe, Jennifer Pack, Jennie Yeh, Joanna Yoa, Joshua Yi, Julie DePetro, Lillian Harris, Lola Aldrige, Martha Ibarra, Michael Jingo, Patrice Daniels, Patricia Lee, Rick Michel, Sharon Jack, Teresa Magana, Tiffany Johnson, and Viraseni Wu, Barbra Cohen, Brenda St. Louis, Camellia Corrica, Caryn Moeller, Chaya Wald, Delores McLeod, Denine Polen, Jean O'Doherty, Jiji George, Karen Chung, Lisa Marie Horne, Lorraine Marshall-Williams, Natasha HarrisRavella Jainarain, Salwa Khouri, Svetlana Sakirsky, Tamara Desvarieux, and Vivian Barber, Arthur Myers, Augusta Boyd, Ashley Simela, Crystal Burke, Kaththryn Koebbe, Linda Kibot, Maureen Kilrain, Melanie Nosan, Melissa Fourmann, Misty Uhi, Monique Howard, Pamela Crider, Raja Shaheen, Rhonda Casey, Robin Sloane, Sandra Smith, Scott Rawlings, Sean Haig, Sharon Noffsinger, Stacey Mathews, Susan Quirk, and Tanya McKnight-Tuffour.

95. Wellpoint was the only defendant Health Plan that attempted to perform a pre-contractual audit. Relator is informed and believes that Wellpoint's first audit was during or about June 2011. MedXM failed the critical elements of the audit for, among other reasons, failing to have a compliance program, failing to have an effective credentialing process, and not conducting and documenting compliance and HIPAA training. As a result, Wellpoint issued a corrective action plan (CAP) to MedXM to correct same as a condition of starting the Wellpoint/MedXM contract for health assessment services.

96. Wellpoint performed a second audit during or about September 2011 to determine whether MedXM had complied with the CAP. MedXM also failed this "pre-contractual" audit because, among other things, MedXM had not conducted and documented compliance and HIPAA training, did not have a compliance plan, and did not have an effective

credentialing process. However, this second "pre-contractual" audit was of no consequence because Wellpoint had already commenced utilizing MedXM to perform Health assessments and/or the Wellpoint/MedXM contract had already been executed without regard to the results of Wellpoint's second "pre-contractual" audit.

97. Subsequently, during or about March or April 2012, Wellpoint conducted another "pre-contractual" audit to determine if MedXM had complied with the CAP. By then, MedXM had manufactured the required compliance plan polices and placed forged and/or inaccurate certificates in its staffs' personnel files indicating that they had received the minimally required HIPAA training as part of their employee orientation, as well as training for fraud, waste and abuse. The training that did occur was a sham; not all employees actually received the training as claimed, the training was not done in a serious manner and was otherwise inadequate, and the employees were given the answer key along with the examination that followed the training. MedXM still had not designated a compliance officer. During this final pre-contractual audit/CAP follow-up visit, Wellpoint removed its CAP even though MedXM still did not have a functional compliance plan until it hired a compliance officer. Wellpoint's contract manager advised MedXM that Wellpoint removed the CAP requirements because MedXM was producing health assessment reports for Wellpoint with high HCC risk adjustment scores.

98. Shortly thereafter, Relator was invited to a celebratory lunch hosted by the MedXM CEO and attended by, among others, key Wellpoint managed care network personnel. The Wellpoint personnel revealed that they had instructed their auditor to remove the CAP because of the increased HCC risk adjustment scores resulting from MedXM's risk assessment submissions. Wellpoint informed MedXM that it would have to designate someone as an actual compliance officer in time for the annual audit to take place during or about June or July 2012. This resulted in Relator being named to the post of compliance officer during or about May 2012. MedXM's CEO advised Relator that she would just hold the position in title on paper only as a figure-head with no additional responsibilities because of her ongoing duties as Director of Provider Relations. Wellpoint quickly became MedXM's single largest health

plan contract.

99. During or about June 2012, Wellpoint conducted an audit of MedXM and determined that MedXM did not have documentation establishing that MedXM's NPs and PAs were working in collaboration with, or being supervised by, a Medicare physician as required by applicable federal and state law. Wellpoint issued a CAP to MedXM requiring it to obtain and maintain such documentation. However, Wellpoint continued to accept RAD from MedXM NPs and PAs even though such documentation was not obtained. Relator is informed and believes that during or about November 2014, Wellpoint again audited MedXM and again determined that MedXM did not have documentation establishing that MedXM's NPs and PAs were working in collaboration with, or being supervised by, a Medicare physician as required by applicable federal and state law. In spite of MedXM's continuing failure to obtain and maintain such documentation, Wellpoint continued to accept MedXM's RAD from MedXM NPs and PAs, and took no action to withdraw from CMS the RAD from same.

100. Wellpoint's exercise of conducting the audits was not a good faith effort to avoid receiving overpayments nor to reduce fraud. Instead, it was a sham designed to paper over Wellpoint's and MedXM's collective compliance deficiencies with a vernier of compliance. Wellpoint's actions expedited MedXM's preparation and submission to Wellpoint of false health assessment reports and RAD. Wellpoint accepted all of the health assessment reports MedXM performed with full knowledge that MedXM did not have a compliance plan, had not conducted any compliance training, and did not have a compliance officer. Wellpoint then submitted the RAD derived from MedXM's improper health assessments to CMS in order to increase Wellpoint's HCC risk adjustment scores, and thus capitated payments from CMS. Wellpoint's initial audit revealed, among other things, that:

i. MedXM did not perform HIPAA employee training as part of employee orientation;

ii. MedXM did not provide employee training for fraud, waste and abuse as part of employee orientation; and

iii. MedXM did not have a Compliance Officer, compliance plan or any

policy and procedures related thereto.

101. Instead of suspending further work and voiding any health assessment reports previously submitted by MedXM, Wellpoint increased the volume of health assessment assignments performed by MedXM by more than 300% during Relator's employment with MedXM.

102. At all times relevant, Health Net knew that the MedXM health assessment reports of Health Net's MA enrollees did not have valid authenticating signatures. As previously alleged, CMS requires that the information on the health assessment reports be authenticated by an handwritten signature or a valid digitally encrypted or electronic signature. The MedXM health assessment reports only contained typed names of the medical examiners, which is not an acceptable signature method, resulting in the MedXM health assessment not being properly documented, and the resulting RAD invalid. Nonetheless, Health Net submitted the MedXM RAD to CMS resulting in factually false claims.

103. Paragraph 49 provides a number of medical conditions that are not possible to make a confirming medical diagnosis of during the MedXM in-home health assessments because confirming such diagnoses requires additional information or testing that were not available to the MedXM medical examiners while performing the health assessments when the health assessment reports were prepared. Silingo is informed and believes and thereupon alleges that many of the medical diagnoses identified in paragraph 49 were included in the MedXM health assessments reports of Health Net's MA enrollees. Each of the diagnoses identified in paragraph 49 also corresponds to a HCC diagnosis code, and causes an increase in the assessed MA enrollees risk adjustment score, and therefore caused an increase in the capitation payments that Health Net received for that MA enrollee in subsequent periods. As a MAO contracted with CMS, Health Net knew that the medical diagnoses identified in paragraph 49 and their related HCC diagnosis codes cannot be confirmed during the health assessments that Health Net requested MedXM to perform. Health Net's submission to CMS of the RAD originating from the MedXM health assessment reports that contain any of the medical diagnoses and/or their related HCC diagnosis codes identified in paragraph 49 results

in factually false claims.

104. Health Net should have known as a result of its requirement to oversee and monitor the delegation of credentialing to MedXM that MedXM's credentialing process failed to document the NPs collaboration or compliance with applicable state law licensure restrictions. Health Net either knew or acted with reckless disregard regarding accepting RAD from MedXM NPs who were practicing outside the scope of their license. As part of the Health Net's compliance program, it was required to perform a risk assessment to determine areas of its and MedXM's FWA vulnerability. Most states did not allow NPs to make medical diagnoses (required for supporting documentation for HCC diagnoses) as opposed to nursing diagnoses, unless the NPs are working in collaboration with a physician and practicing under standardized practice protocols that provide for the extension of the NPs scope of practice to include making medical diagnoses. These arrangements are typically part of an employment relationship between the NP and healthcare facility or medical clinic, and do not apply for independent contractor work on patients unrelated to that collaborative employment relationship.

105. Health Net's submission of RAD supported by health assessments performed by large numbers of independent NPs is a high risk issue for potential FWA. The MedXM NPs were not employees nor supervised by MedXM. Rather, MedXM's NPs were independently contracted to perform health assessments of Health Net's MA enrollees. Because most states do not allow independent NPs to make medical diagnoses, the high percentage of NPs used by MedXM should have been a serious red flag of Medicare fraud and raised concerns as part of Health Net's risk assessment function and its compliance program in general. Accordingly, Health Net should have known that MedXM's NPs were in fact practicing outside the scope of their licensure, and in conjunction with MedXM's failure to document that its contracted NPs were working collaboration with a physician, should have triggered a fraud investigation by Health Net. Health Net did not act and did not initiate a fraud investigation or even a issued CAP regarding NP credentialing. Rather, Health Net acted with reckless disregard for the truth in failing to identify the fraudulent RAD from NPs

practicing outside the scope of their licensure because they were not working in collaboration with a licensed physician or under standardized practice guidelines that would extend the scope of their practice to include medical diagnoses. This results in both factually and legally false claims because Health Net's certification of RAD cannot extend to medical examiners who are outside the scope of their practice.

106. The NPs that performed health assessments of Health Net's MA enrollees made improper medical diagnoses (resulting in invalid RAD and HCC diagnosis codes) outside the scope of their practice because they were not working in collaboration with licensed physicians and/or in compliance with applicable state law licensure restrictions. The Health Net-authorized NPs include, but are not limited to:

> Alda O'Conner, Carina Viscona-Pons, Catherine Cusi, Christian Eggleston, Colette Spencer, Doreen Urban, Janice Cahambing, Jason Speaks, Jayson Hoppe, Jennifer Pack, Jennie Yeh, Joanna Yoa, Joshua Yi, Julie DePetro, Lillian Harris, Lola Aldrige, Martha Ibarra, Michael Jingo, Patrice Daniels, Patricia Lee, Rick Michel, Sharon Jack, Teresa Magana, Tiffany Johnson, and Viraseni Wu, Babra Henderson, Christy Middleton, Dean Wentworth, Jeff Pentecost, Monique Noyes Nancy Hutt.

107. At all times relevant, Alameda knew that the MedXM health assessment reports of Alameda's MA enrollees did not have valid authenticating signatures. As previously alleged, CMS requires that the information on the health assessment reports be authenticated by an handwritten signature or a valid digitally encrypted or electronic signature. The MedXM health assessment reports only contained typed names of the medical examiners, which is not an acceptable signature method, resulting in the MedXM health assessment not being properly documented, and the resulting RAD invalid. Nonetheless, Alameda submitted the MedXM RAD to CMS resulting in factually false claims.

108. Paragraph 49 provides a number of medical conditions that are not possible to make a confirming medical diagnosis of during the MedXM in-home health assessments because confirming such diagnoses requires additional information or testing that were not available to the MedXM medical examiners while performing the health assessments when

the health assessment reports were prepared. Silingo is informed and believes and thereupon alleges that many of the medical diagnoses identified in paragraph 49 were included in the MedXM health assessments reports of Alameda's MA enrollees. Each of the diagnoses identified in paragraph 49 also corresponds to a HCC diagnosis code, and causes an increase in the assessed MA enrollees risk adjustment score, and therefore caused an increase in the capitation payments that Alameda received for that MA enrollee in subsequent periods. As a MAO contracted with CMS, Alameda knew that the medical diagnoses identified in paragraph 49 and their related HCC diagnosis codes cannot be confirmed during the health assessments that Alameda requested MedXM to perform. Alameda's submission to CMS of the RAD originating from the MedXM health assessment reports that contain any of the medical diagnoses and/or their related HCC diagnosis codes identified in paragraph 49 results in factually false claims.

109. Alameda should have known as a result of its requirement to oversee and monitor the delegation of credentialing to MedXM that MedXM's credentialing process failed to document the NPs collaboration or compliance with applicable state law licensure restrictions. Alameda either knew or acted with reckless disregard regarding accepting RAD from MedXM NPs who were practicing outside the scope of their license. As part of the Alameda's compliance program, it was required to perform a risk assessment to determine areas of its and MedXM's FWA vulnerability. Most states did not allow NPs to make medical diagnoses (required for supporting documentation for HCC diagnoses) as opposed to nursing diagnoses, unless the NPs are working in collaboration with a physician and practicing under standardized practice protocols that provide for the extension of the NPs scope of practice to include making medical diagnoses. These arrangements are typically part of an employment relationship between the NP and healthcare facility or medical clinic, and do not apply for independent contractor work on patients unrelated to that collaborative employment relationship.

110. Alameda's submission of RAD supported by health assessments performed by large numbers of independent NPs is a high risk issue for potential FWA. The MedXM NPs

were not employees nor supervised by MedXM. Rather, MedXM's NPs were independently contracted to perform health assessments of Alameda's MA enrollees. Because most states do not allow independent NPs to make medical diagnoses, the high percentage of NPs used by MedXM should have been a serious red flag of Medicare fraud and raised concerns as part of Alameda's risk assessment function and its compliance program in general. Accordingly, Alameda should have known that MedXM's NPs were in fact practicing outside the scope of their licensure, and in conjunction with MedXM's failure to document that its contracted NPs were working collaboration with a physician, should have triggered a fraud investigation by Alameda. Alameda did not act and did not initiate a fraud investigation or even a issued CAP regarding NP credentialing. Rather, Alameda acted with reckless disregard for the truth in failing to identify the fraudulent RAD from NPs practicing outside the scope of their licensure because they were not working in collaboration with a licensed physician or under standardized practice guidelines that would extend the scope of their practice to include medical diagnoses. This results in both factually and legally false claims because Alameda's certification of RAD cannot extend to medical examiners who are outside the scope of their practice.

111. The NPs that performed health assessments of Alameda's MA enrollees made improper medical diagnoses (resulting in invalid RAD and HCC diagnosis codes) outside the scope of their practice because they were not working in collaboration with licensed physicians and/or in compliance with applicable state law licensure restrictions. The Alameda-authorized NPs include, but are not limited to:

Alda O'Conner, Carina Viscona-Pons, Catherine Cusi, Christian Eggleston, Colette Spencer, Doreen Urban, Janice Cahambing, Jason Speaks, Jayson Hoppe, Jennifer Pack, Jennie Yeh, Joanna Yoa, Joshua Yi, Julie DePetro, Lillian Harris, Lola Aldrige, Martha Ibarra, Michael Jingo, Patrice Daniels, Patricia Lee, Rick Michel, Sharon Jack, Teresa Magana, Tiffany Johnson, and Viraseni Wu.

112. At all times relevant, VNS knew that the MedXM health assessment reports of VNS's MA enrollees did not have valid authenticating signatures. As previously alleged,

CMS requires that the information on the health assessment reports be authenticated by an handwritten signature or a valid digitally encrypted or electronic signature. The MedXM health assessment reports only contained typed names of the medical examiners, which is not an acceptable signature method, resulting in the MedXM health assessment not being properly documented, and the resulting RAD invalid. Nonetheless, VNS submitted the MedXM RAD to CMS resulting in factually false claims.

113. Paragraph 49 provides a number of medical conditions that are not possible to make a confirming medical diagnosis of during the MedXM in-home health assessments because confirming such diagnoses requires additional information or testing that were not available to the MedXM medical examiners while performing the health assessments when the health assessment reports were prepared. Silingo is informed and believes and thereupon alleges that many of the medical diagnoses identified in paragraph 49 were included in the MedXM health assessments reports of VNS's MA enrollees. Each of the diagnoses identified in paragraph 49 also corresponds to a HCC diagnosis code, and causes an increase in the assessed MA enrollees risk adjustment score, and therefore caused an increase in the capitation payments that VNS received for that MA enrollee in subsequent periods. As a MAO contracted with CMS, VNS knew that the medical diagnoses identified in paragraph 49 and their related HCC diagnosis codes cannot be confirmed during the health assessments that VNS requested MedXM to perform. VNS's submission to CMS of the RAD originating from the MedXM health assessment reports that contain any of the medical diagnoses and/or their related HCC diagnosis codes identified in paragraph 49 results in factually false claims.

114. VNS should have known as a result of its requirement to oversee and monitor the delegation of credentialing to MedXM that MedXM's credentialing process failed to document the NPs collaboration or compliance with applicable state law licensure restrictions. VNS either knew or acted with reckless disregard regarding accepting RAD from MedXM NPs who were practicing outside the scope of their license. As part of the VNS's compliance program, it was required to perform a risk assessment to determine areas of its and MedXM's FWA vulnerability. Most states did not allow NPs to make medical diagnoses (required for

supporting documentation for HCC diagnoses) as opposed to nursing diagnoses, unless the NPs are working in collaboration with a physician and practicing under standardized practice protocols that provide for the extension of the NPs scope of practice to include making medical diagnoses. These arrangements are typically part of an employment relationship between the NP and healthcare facility or medical clinic, and do not apply for independent contractor work on patients unrelated to that collaborative employment relationship.

115. VNS's submission of RAD supported by health assessments performed by large numbers of independent NPs is a high risk issue for potential FWA. The MedXM NPs were not employees nor supervised by MedXM. Rather, MedXM's NPs were independently contracted to perform health assessments of VNS's MA enrollees. Because most states do not allow independent NPs to make medical diagnoses, the high percentage of NPs used by MedXM should have been a serious red flag of Medicare fraud and raised concerns as part of VNS's risk assessment function and its compliance program in general. Accordingly, VNS should have known that MedXM's NPs were in fact practicing outside the scope of their licensure, and in conjunction with MedXM's failure to document that its contracted NPs were working collaboration with a physician, should have triggered a fraud investigation by VNS. VNS did not act and did not initiate a fraud investigation or even a issued CAP regarding NP credentialing. Rather, VNS acted with reckless disregard for the truth in failing to identify the fraudulent RAD from NPs practicing outside the scope of their licensure because they were not working in collaboration with a licensed physician or under standardized practice guidelines that would extend the scope of their practice to include medical diagnoses. This results in both factually and legally false claims because VNS's certification of RAD cannot extend to medical examiners who are outside the scope of their practice.

116. The NPs that performed health assessments of VNS's MA enrollees made improper medical diagnoses (resulting in invalid RAD and HCC diagnosis codes) outside the scope of their practice because they were not working in collaboration with licensed physicians and/or in compliance with applicable state law licensure restrictions. The VNS-authorized NPs include, but are not limited to:

Barbra Cohen, Brenda St. Louis, Camellia Corrica, Caryn Moeller, Chaya Wald, Delores McLeod, Denine Polen, Jean O'Doherty, Jiji George, Karen Chung, Lisa Marie Horne, Lorraine Marshall-Williams, Natasha Harris, Ravella Jainarain, Salwa Khouri, Svetlana Sakirsky, Tamara Desvarieux, and Vivian Barber.

117. At all times relevant, Molina knew that the MedXM health assessment reports of Molina's MA enrollees did not have valid authenticating signatures. As previously alleged, CMS requires that the information on the health assessment reports be authenticated by an handwritten signature or a valid digitally encrypted or electronic signature. The MedXM health assessment reports only contained typed names of the medical examiners, which is not an acceptable signature method, resulting in the MedXM health assessment not being properly documented, and the resulting RAD invalid. Nonetheless, Molina submitted the MedXM RAD to CMS resulting in factually false claims.

118. Paragraph 49 provides a number of medical conditions that are not possible to make a confirming medical diagnosis of during the MedXM in-home health assessments because confirming such diagnoses requires additional information or testing that were not available to the MedXM medical examiners while performing the health assessments when the health assessment reports were prepared. Silingo is informed and believes and thereupon alleges that many of the medical diagnoses identified in paragraph 49 were included in the MedXM health assessments reports of Molina's MA enrollees. Each of the diagnoses identified in paragraph 49 also corresponds to a HCC diagnosis code, and causes an increase in the assessed MA enrollees risk adjustment score, and therefore caused an increase in the capitation payments that Molina received for that MA enrollee in subsequent periods. As a MAO contracted with CMS, Molina knew that the medical diagnoses identified in paragraph 49 and their related HCC diagnosis codes cannot be confirmed during the health assessments that Molina requested MedXM to perform. Molina's submission to CMS of the RAD originating from the MedXM health assessment reports that contain any of the medical diagnoses and/or their related HCC diagnosis codes identified in paragraph 49 results in factually false claims.

119. Molina acted with reckless disregard by failing to initiate a fraud investigation when it noticed that approximately 400 of the health assessment reports performed by Dr. Awaisi contained duplicate vital statistics data for age, sex, height, weight, blood pressure and resting pulse. Upon noticing this discrepancy Molina contacted MedXM and asked MedXM to fix the problem. In response MedXM's CEO, Sy Zahedi, informed Molina that the duplicate data was due to a printer malfunction and that MedXM would submit new health assessment reports. This is not plausible explanation because printers do not malfunction in that manner when printing PDF documents. This was also a lie. MedXM knew that the duplications were a result of Dr. Awaisi failing to conduct face-to face encounters. Molina accepted MedXM's fabricated health assessments made to look more authentic with the assistance of MedXM senior management. Molina should have initiated a full fraud investigation to determine the full extent of Dr. Awasi's misdeeds. Instead, Molina turned a blind eye and acted in reckless disregard of the truth that the risk adjustment reports were fraudulent. Dr. Awaisi typically performed in excess of 20 health assessments per day for Molina. This number is not plausible on its face and Molina, the recipient of Dr. Awaisi's health assessment reports knew or should have known the reports were fraudulent.

120. Molina should have known as a result of its requirement to oversee and monitor the delegation of credentialing to MedXM that MedXM's credentialing process failed to document the NPs' collaboration or compliance with applicable state law licensure restrictions. Molina either knew or acted with reckless disregard regarding accepting RAD from MedXM NPs who were practicing outside the scope of their licensure. As part of Molina's compliance program, it was required to perform a risk assessment to determine areas of its and MedXM's FWA vulnerability. Most states did not allow NPs to make medical diagnoses (required for supporting documentation for HCC diagnoses) as opposed to nursing diagnoses, unless the NPs are working in collaboration with a physician and practicing under standardized practice protocols that provide for the extension of the NPs scope of practice to include making medical diagnoses. These arrangements are typically part of an employment relationship between the NP and healthcare facility or medical clinic, and do not apply for independent

contractor work on patients unrelated to that collaborative employment relationship.

121. Molina's submission of RAD supported by health assessments performed by large numbers of independent NPs is a high risk issue for potential FWA. The MedXM NPs were not employees nor supervised by MedXM. Rather, MedXM's NPs were independently contracted to perform health assessments of Molina's MA enrollees. Because most states do not allow independent NPs to make medical diagnoses, the high percentage of NPs used by MedXM should have been a serious red flag of Medicare fraud and raised concerns as part of Molina's risk assessment function and its compliance program in general. Accordingly, Molina should have known that MedXM's NPs were in fact practicing outside the scope of their licensure, and in conjunction with MedXM's failure to document that its contracted NPs were working collaboration with a physician, should have triggered a fraud investigation by Molina. Molina did not act and did not initiate a fraud investigation or even a issued CAP regarding NP credentialing. Rather, Molina acted with reckless disregard for the truth in failing to identify the fraudulent RAD from NPs practicing outside the scope of their licensure because they were not working in collaboration with a licensed physician or under standardized practice guidelines that would extend the scope of their practice to include medical diagnoses. This results in both factually and legally false claims because Molina's certification of RAD cannot extend to medical examiners who are outside the scope of their practice.

122. The NPs that performed health assessments of Molina's MA enrollees made improper medical diagnoses (resulting in invalid RAD and HCC diagnosis codes) outside the scope of their practice because they were not working in collaboration with licensed physicians and/or in compliance with applicable state law licensure restrictions. The Molina-authorized NPs include, but are not limited to:

Alda O'Conner, Carina Viscona-Pons, Catherine Cusi, Christian Eggleston, Colette Spencer, Doreen Urban, Janice Cahambing, Jason Speaks, Jayson Hoppe, Jennifer Pack, Jennie Yeh, Joanna Yoa, Joshua Yi, Julie DePetro, Lillian Harris, Lola Aldrige, Martha Ibarra, Michael Jingo, Patrice Daniels, Patricia Lee, Rick Michel, Sharon Jack,

Teresa Magana, Tiffany Johnson, and Viraseni Wu, Brandy Evans, Hawa Stinson, and Munachi Okpala, Chenaull Jordon, Christopher Green, Dallas Valentine, Dusty Filliung, Harriet Willimas-Sloan, Rizwan Ibadat, Kasheena Shropshire

123. At all times relevant, 42 C.F.R. § 422.504(i) required the defendant Health Plans to maintain ultimate responsibility for their first tier, downstream and related entities' full compliance with and adherence to all terms and conditions of the defendant Health Plans' contracts with CMS (MedXM was a first tier entity). Further, the defendant Health Plans' contracts with MedXM are required to contain a provision that the defendant Health Plans must monitor MedXM's performance on an ongoing basis. This provision makes the defendant Health Plans strictly liable for the acts of their contractors, such as MedXM, and imposes a contractual obligation to monitor such contractors' performance, thereby contractually mandating the ability to perform the compliance plan obligations found in 42 C.F.R. § 422.503(b)(4)(vi), (*see also*, 79 Fed. Reg. 29844, 29923 (May 23, 2014).) The defendant Health Plans failed to monitor the performance of MedXM and failed to discover and/or acted in reckless disregard for the truth regarding MedXM's failure to adhere and comply with CMS regulations regarding (a) the accuracy of the risk adjustment data that MedXM submitted, (b) compliance with HIPAA regulations, (c) compliance with documentation standards, and (d) physicians' signature requirements. Further, as previously discussed, the defendant Health Plans utterly failed to implement any type of effective compliance program with regard to the acceptance of risk adjustment data from MedXM. Adherence with the requirements to have an effective compliance program is a material requirement for qualifying for, maintaining, and receiving payment under, a Medicare Advantage contract with CMS. The defendant Health Plans' failures to implement effective compliance programs and properly monitor the performance of MedXM results in an implied false certification of a material fact to obtain payment from CMS.

124. At all times relevant, 42 C.F.R. § 422.504(l)(2) required the defendant Health Plans, as a condition of receiving their monthly capitation payments, to certify to CMS that the RAD submitted to CMS are accurate, complete and truthful (which includes having

compliance programs in place to prevent, detect and correct fraud, waste, abuse and non-compliance with CMS program requirements.) Further, 42 C.F.R. § 422.504(l)(3) required that in cases where the RAD is generated by a contractor, such as MedXM, the contractor must also attest to the accuracy, completeness and truthfulness of the risk adjustment data it submitted to MAOs, including the defendant Health Plans (which includes having compliance programs in place to prevent, detect and correct fraud, waste, abuse and non-compliance with CMS program requirements.) .

125. The attestations made by the defendant Health Plans regarding the accuracy, truthfulness and completeness of any and all risk adjustment data submitted to them by MedXM was either knowingly false or made with a reckless disregard for the truth of the matter. Because the defendant Health Plans utterly failed to maintain an effective compliance program as required by 42 C.F.R. § 422.503, as explained in the foregoing paragraphs, the defendant Health Plans had no basis on which to make an attestation and no basis on which to accept MedXM's attestation regarding the same. Because the attestation requirement statute expressly requires compliance as a condition of receiving monthly capitation payments, the defendant Health Plans' violations resulted in an express false certification of a material fact to obtain payment from CMS. (*See,* 79 Fed. Reg. 29844, 29923 (May 23, 2014).)

FIRST CLAIM FOR RELIEF

(Violation of 31 U.S.C. § 3729(a) against all defendants)

126. Relator realleges and incorporates by reference all previous paragraphs of this complaint as though fully set forth at length.

127. At all times mentioned, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1) by:

i. Knowingly presenting and/or causing to present to agents, contractors or employees of the Government false and fraudulent claims for payment and approval; and

ii. Knowingly making, using, and/or causing to make or use false records

and statements to get false and excessive claims paid or approved by Medicare.

128. Relator is informed and believes, and upon such information and belief alleges, that as a result of defendants' fraudulent misconduct, the Government was damaged in excess of $1,000,000,000.

129. As a result of defendants' conduct, defendants are liable to the Government for three times the amount of damages sustained by the Government as a result of the false and fraudulent claims alleged above.

130. As a result of defendants' conduct, 31 U.S.C. § 3729(a) provides that defendants are liable to the Government for civil penalties between $5,000 and $10,000 for each such false and fraudulent claim for payment.

131. Relator is also entitled to recover her attorneys fees, costs and expenses from defendants pursuant to 31 U.S.C. § 3730(d).

SECOND CLAIM FOR RELIEF

(Violation of 31 U.S.C. § 3730(h) against MedXM)

132. Relator realleges and incorporates by reference all previous paragraphs of this complaint as though fully set forth at length.

133. During or about late spring or early summer of 2012, in response to defendant Wellpoint's upcoming annual contract audit, MedXM's compliance consultant Katrina Pelto informed MedXM's CEO, Human Resources Director Diane Bailey, and Relator that MedXM was required to hire a compliance officer, i.e., one who reports directly to the CEO and is vested with the day-to-day operations of MedXM's compliance program requirements, defines the program structure, educational requirements, reporting and complaint mechanisms, response and correction procedures, and compliance expectations of all personnel and FDRs, and does not serve in both compliance and operational areas. (*See*, 42 C.F.R. § 422.504(b)(4)(iv)(B)(1); Medicare Managed Care Manual, Ch 21, §§ 50.2, 50.2.1.) Ms. Pelto, MedXM's CEO, and Ms. Bailey suggested Relator be assigned as the near term Compliance

Officer for the upcoming Wellpoint audit because Relator already had a direct reporting relationship with MedXM's CEO, a statutory requirement for the position. Relator accepted the title of Compliance Officer with the clear understanding with MedXM's CEO, Ms. Pelto and Ms. Bailey that Relator would continue performing her duties as Director of Provider Relations, Relator did not have time to perform the additional duties of a Compliance Officer, Ms. Pelto would perform the Compliance Officer duties, and that Realtor would only be the Compliance Officer "on paper" for the near term with respect to the Wellpoint/MedXM agreement and audit. Relator informed MedXM's CEO, Ms. Pelto and Ms. Bailey that Relator had no experience in compliance and had no idea what a Compliance Officer was supposed to do.

134. MedXM's CEO assured Relator that she would have virtually no additional responsibilities, duties or expectations as a result of this new "title," Ms. Pelto would perform all compliance tasks and duties (even though Ms. Pelto was not working full time for MedXM and was not a MedXM employee), and would continue to perform her responsibilities as Director of Provider Relations without change. No one at MedXM explained to Relator any new job functions, duties or responsibilities associated with the Compliance Officer title, and as promised, MedXM's CEO never gave Relator any assignments or tasks related to her Compliance Officer title. Aside from Wellpoint, no other health plan requested a copy of MedXM's compliance plan and MedXM did not provide a copy to any other health plan or regulatory agency. Relator's job description was not changed in any manner to reflect any Compliance Officer responsibilities and she was not given any additional pay or business cards with the new title. MedXM never sent her to any conferences nor training seminars regarding compliance issues or to educate her regarding the Compliance Officer function. Relator was never called upon to perform any function or task in the capacity of Compliance Officer.

135. The compliance plan functions were handled directly by MedXM's CEO with assistance from MedXM's consultant, Ms. Pelto. Ms. Pelto scheduled two semi-annual compliance committee meetings which Relator attended. The meeting agendas and minutes were prepared by Ms. Pelto with minimal input from Relator. Ms. Pelto chaired both

compliance committee meetings and did most of the talking. At the conclusion of the meetings, Ms. Pelto presented the meeting minutes to MedXM's CEO for signature.

136. The situation began to change for Relator during or about January 2013 as a result of the fraudulent activity involving in Dr. Awaisi previously described. During late December 2012, MedXM's CEO, as well as MedXM's Vice President of Operations, were out of town when the initial call to MedXM was received from Molina informing MedXM that there was a problem with a number of Dr. Awaisi's health assessment reports received during the past few months. MedXM's Vice President initially asked Relator to look into the matter on her behalf, as Relator was one of the more experienced health care managers currently onsite. Relator discovered that Dr. Awaisi had fabricated patient findings in approximately 750 health assessments performed on Molina enrollees in Michigan (the assessment reports contained cookie cutter type duplicate findings) and that in many cases Dr. Awaisi sent his medical assistant to conduct the in-home health assessments in violation of federal law requiring encounters to be the result of face-to-face visits. After reporting back to MedXM's Vice President, Relator was instructed to let MedXM's COO, Mohsen Zahedi, handle the balance of the Dr. Awaisi incident. To Relator's dismay, MedXM's COO instructed the MedXM scheduling department staff to telephonically gather new clinical data from the Molina MA enrollees (that were the subject of the health assessment reports identified by Molina) and provide same to Dr. Awaisi so that he could alter the duplicate findings contained in the health assessment reports previously submitted to Molina, in addition to altering approximately 350 similarly flawed health assessment reports that had not yet been forwarded to Molina.

137. Prior to MedXM's COO submitting Dr. Awaisi's revised, but still fraudulent, health assessment reports back to Molina, during or about January 2013 Silingo informed MedXM's CEO that MedXM needed to withdraw all of Dr. Awaisi's health assessment reports from Molina (including those that pre-dated the health assessments that were the subject of Molina's inquiry), notify Molina of the problem with Dr. Awaisi's data so Molina could investigate the issue further, terminate Dr. Awaisi effective immediately, and have

MedXM conduct a complete investigation to identify the extent of Dr. Awaisi's fraud. CEO Zahedi replied, "Dr. Awaisi may be a crook but he's our crook" and authorized the submission of the health assessment reports altered by Dr. Awaisi that contained new clinical data telephonically collected by MedXM's schedulers, and refused to have MedXM review or recall Dr. Awaisi's health assessments that predated those that were the subject of Molina's inquiry. MedXM's CEO misrepresented to Molina that Dr. Awaisi's duplicate data was the result of a printer glitch and the issue was resolved. During or about the latter half of January 2013, Relator advised MedXM's COO that Dr. Awaisi's improper practices constituted fraud, and MedXM's COO instructed Relator not to "say that word" to MedXM's CEO because "he doesn't want to hear it." After witnessing MedXM's senior management knowingly submit fraudulently created health assessment reports to Molina, Relator became concerned that allowing her employer to use her name as the Compliance Officer could damage her professional reputation.

138. This concern was soon validated during or about March 2013 when Relator witnessed MedXM's COO instruct MedXM staff to alter Dr. Robinson's health assessment reports to conceal the fact the assessment reports contained duplicate findings that were not the product of face-to-face encounters.

139. On or about April 1, 2013, Relator sent MedXM's CEO an email resigning the use of her name as MedXM's Compliance Officer effective immediately. Later that day, MedXM's CEO came to inquire as to her specific reasons. During this and other conversations, MedXM's CEO acknowledged that Relator no longer held the title of Compliance Officer, and Relator complained to MedXM's CEO that:

i. MedXM's health assessment reports amendments and changes, and improper queries of the medical examiners by MedXM coders made the health assessment reports fraudulent;

ii. MedXM's use of unlocked Word medical records, amendments and corrections thereto, and failure to use digitally encrypted signatures constituted frauds upon the MAOs and CMS; and

iii. MedXM's continued employment and utilization of Dr. Awaisi and other medical examiners who MedXM knew fabricated medical findings and routinely violated the face-to-face encounter requirements constituted a frauds upon the MAOs and CMS.

140. About a week later, Relator had a similar conversation with MedXM's COO.

141. As a result of Relator complaining of such misconduct, MedXM retaliated against Relator in violation of 31 U.S.C. § 3730(h)(1) by discriminating against Relator in the terms and conditions of her employment and/or subjecting her to a hostile work environment that included, but was not limited to:

i. Refusing to investigate, correct or take appropriate action to correct the fraudulent misconduct Relator complained of;

ii. Shortly after Relator resigned as compliance officer, MedXM's CEO promoted one of Relator's subordinates and direct reports, Brian Hazel, without consulting Relator, to report directly to MedXM's CEO to write MedXM's Coding Department's policies and procedures without informing or consulting Relator (the Coding Supervisors reported to Relator);

iii. During or about May 2013, MedXM's CEO excluded Relator from continuing to complete a patient post-discharge project she was working on with defendant Wellpoint without any explanation. The project was part of Relator's job functions as Director of Provider Relations;

iv. On or about April 15, 2013, MedXm's CEO told Relator on more than one occasion that, "you are rubbing everyone the wrong way" because Relator complained of various compliance issues and further told Relator that to stop making such complaints;

v. Hiring Relator's replacement as Director of Provider Relations before terminating Relator;

vi. Terminating Relator's employment during June 2013; and

vii. Withholding pay and penalties due Relator at the time of her termination under *California Labor Code* §§ 201(a) and 203.

142. As a result of such retaliation and discrimination, Relator has suffered, and will continue to suffer, emotional distress, worry, anxiety and humiliation in an amount according to proof at trial.

143. In retaliating against Relator, MedXM acted with fraud, oppression and malice, warranting an award of punitive damages against MedXM in an amount to be determined at trial.

144. Relator is also entitled to recover her attorneys fees, costs and expenses pursuant to 31 U.S.C. § 3730(h)(2).

THIRD CLAIM FOR RELIEF

(Violation of *California Labor Code* §§ 201, et seq. against MedXM)

145. Relator realleges and incorporates by reference all previous paragraphs of this complaint as though fully set forth at length.

146. MedXM wilfully failed to timely pay Relator compensation due her as required by *California Labor Code* § 201(a) in an amount according to proof.

147. In addition to her unpaid compensation, Relator is entitled to recover penalties from MedXM pursuant to *California Labor Code* § 203 in an amount according to proof.

148. Relator is entitled to prejudgment interest on the amount due pursuant to *California Labor Code* § 218.6.

149. Relator is entitled to reasonable attorney's fees and costs incurred pursuant to *California Labor Code* § 218.5.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff and Qui Tam Relator prays for relief as follows:

FOR THE FIRST CLAIM FOR RELIEF

1. Treble the Government's damages according to proof;

2. Civil penalties according to proof;

3. A relator's award of up to 30% of the amounts recovered by or on behalf of the Government;

FOR THE SECOND CLAIM FOR RELIEF

4. General damages in amount according to proof;

5. Reinstatement with the same seniority status that Relator would have had but for the discrimination and retaliation;

6. Two times the amount of back pay;

7. Interest on the back pay;

8. Punitive damages according to proof;

FOR THE THIRD CLAIM FOR RELIEF

9. Compensatory damages in amount according to proof;

10. Penalties pursuant to *California Labor Code* § 203 in an amount according to proof;

11. Prejudgment interest on the amount due pursuant to *California Labor Code* § 218.6;

12. Reasonable attorney's fees and costs incurred pursuant to *California Labor Code* § 218.5;

FOR ALL CLAIMS FOR RELIEF

13. Attorneys fees, expenses, and costs; and

14. Such other and further relief as the Court deems just and proper.

THE ZINBERG LAW FIRM
A Professional Corporation

THE HANAGAMI LAW FIRM
A Professional Corporation

Dated: October 21, 2015

By: */s/William K. Hanagami*
William K. Hanagami
Attorneys for Plaintiff and Qui Tam Relator,
Anita Silingo

REQUEST FOR JURY TRIAL

Plaintiff and Qui Tam Relator hereby requests a trial by jury.

THE ZINBERG LAW FIRM
A Professional Corporation

THE HANAGAMI LAW FIRM
A Professional Corporation

Dated: October 22, 2015

By: */s/William K. Hanagami*
William K. Hanagami
Attorneys for Plaintiff and Qui Tam Relator,
Anita Silingo

Complaint.P04A.wpd