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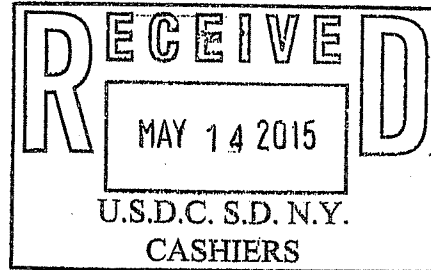


UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA ex rel. DAN BISK,
STATE OF NEW YORK ex rel. DAN BISK,

Plaintiffs,

-against-

WESTCHESTER MEDICAL CENTER,
WESTCHESTER COUNTY HEALTH CARE
CORPORATION, et al.,

Defendants.

UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

-against-

WESTCHESTER COUNTY HEALTH CARE
CORPORATION d/b/a WESTCHESTER MEDICAL
CENTER,

Defendant.

COMPLAINT-IN-INTERVENTION OF THE UNITED STATES OF AMERICA

06 Civ. 15296 (LAK)

Plaintiff United States of America (the "United States" or the "Government"), by its attorney, Preet Bharara, United States Attorney for the Southern District of New York, brings

this action against Westchester County Health Care Corporation d/b/a Westchester Medical Center ("WMC"), alleging upon information and belief as follows:

PRELIMINARY STATEMENT

1. This is a civil action brought by the United States against WMC under the False Claims Act, 31 U.S.C. §§ 3729-33 (the "FCA"), to recover treble damages sustained by, and civil penalties and restitution owed to, the United States based on WMC's violations of the Anti-Kickback Statute (the "AKS"), 42 U.S.C. § 1320a-7b(b), and the Stark Statute, 42 U.S.C. § 1395nn, and its implementing regulations, 42 C.F.R. § 411.350 *et seq.* (collectively, the "Stark Law"), and WMC's filing of cost reports with the Centers for Medicare and Medicaid Services ("CMS"), formerly known as the Health Care Financing Administration ("HCFA"), seeking reimbursement for costs WMC did not incur.

2. As set forth more fully below, from January 1, 2001, through December 31, 2007, the financial relationship between WMC and Cardiology Consultants of Westchester, P.C. ("CCW") violated the AKS and the Stark Law, and WMC's submission of claims to the Medicare Program for services rendered to patients referred to WMC by CCW's shareholder physicians violated the FCA. Additionally, for the cost reports WMC filed for calendar years ending December 31, 2000, through December 31, 2007 with CMS, WMC wrongly sought and obtained reimbursement for certain Direct Graduate Medical Education ("DGME") and Indirect Medical Education ("IME") costs. Specifically, WMC wrongly obtained from Medicare reimbursement for time certain residents and fellows spent at other hospitals or in non-hospital settings, even though WMC did not incur all or substantially all of the costs associated with these fellows or residents, or otherwise meet applicable HCFA/CMS regulatory requirements as set forth at 42 C.F.R. § 413.86 and, later, at 42 C.F.R. § 413.78.

JURISDICTION AND VENUE

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

4. Venue lies in this District pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. §§ 1391(b) and 1391(c).

PARTIES

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

6. Relator Dan Bisk was an employee of WMC who resided in Westchester County, New York State, prior to his death in December 2009. In December 2006, Mr. Bisk filed an action alleging violations of the FCA on behalf of himself, the United States, and the State of New York pursuant to the *qui tam* provisions of the FCA, 31 U.S.C. § 3730(b)(1). Pursuant to the Decree Granting Administration entered by the Surrogate's Court of the State of New York on February 2, 2010, Chris Carrs, Mr. Bisk's wife, was appointed to be the administrator of his estate, and therefore is authorized to pursue this action on his behalf.

7. Defendant WMC is a public benefit corporation that was established in 1997 pursuant to Article 10-C, Title 1 of the New York State Public Authorities Law to manage and operate a tertiary and quartenary care hospital, located in Valhalla, New York. WMC serves as the primary clinical affiliate of New York Medical College ("NYMC").

FACTUAL ALLEGATIONS

I. The Medicare Program

8. The United States, through HHS, administers the Medicare Program for the aged and disabled, established by Title XVIII of the Social Security Act. *See* 42 U.S.C. §§ 1395 *et seq.* Part A of the Medicare Program provides federal payment for patient institutional care, including hospital, skilled nursing facility, and home healthcare. *See* 42 U.S.C. §§ 1395c-1395i-4. Part B of the Medicare Program provides supplemental insurance coverage for medical and other services that are not covered by Part A. 42 U.S.C. §§ 1395j-1395w-4.

9. Under the Medicare Program, CMS makes payments to hospitals for inpatient and outpatient services after the services are rendered. Medicare enters into provider agreements with hospitals and physicians that govern the hospital's participation in the program.

10. To assist in the administration of Medicare Part A, CMS contracts with private non-governmental organizations or "fiscal intermediaries" to, *inter alia*, review and process claims for reimbursement submitted by healthcare providers, including the clams submitted by WMC. 42 U.S.C. § 1395h. Fiscal intermediaries, typically insurance companies, are also responsible for processing and paying claims and auditing cost reports.

11. Upon discharge of Medicare beneficiaries from a hospital, the hospital submits claims for interim reimbursement for items and services delivered to those beneficiaries during their hospital stays. 42 C.F.R. §§ 413.1, 413.60, 413.64. At all times relevant to this complaint, WMC regularly submitted claims to Medicare for interim reimbursement for items and services delivered to Medicare beneficiaries, including those referred to WMC by CCW shareholders.

12. As a prerequisite for payment by Medicare, CMS requires hospitals to submit a Medicare cost report annually at the conclusion of the hospital's fiscal year. The cost report is

the final claim that a hospital files with the fiscal intermediary identifying its costs for services rendered to Medicare beneficiaries and stating the amount of reimbursement which the hospital believes it is due for the year. *See* 42 U.S.C. § 1395g(a); 42 C.F.R. §413.20; *see also* 42 C.F.R. § 405.1081(b)(1).

13. Medicare relies upon the cost report to determine whether the hospital is entitled to more reimbursement than the interim payments that the hospital has received from Medicare during the course of the year, or whether the hospital was overpaid by Medicare, and, consequently, must reimburse Medicare for the excess amounts paid under the program during the course of the year. *See* 42 C.F.R. §§ 405.1803, 413.60, and 413.64(f)(1).

14. At all times relevant to this complaint, WMC was required to and did submit cost reports to its fiscal intermediary.

15. Every Medicare cost report contains a "Certification" that must be signed by the chief administrator of the hospital or a responsible designee of the administrator. The Medicare cost report certification page includes the following notice:

> Misrepresentation or falsification of any information contained in this Cost Report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under federal law. Furthermore, if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or were otherwise illegal, criminal, civil and administrative action, fines and/or imprisonment may result.

16. The responsible hospital official is required to certify, in pertinent part, that:

> To the best of my knowledge and belief, [the cost report and the balance sheet and the statement of revenue expenses] is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of healthcare services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

17. Thus, the hospital must certify that: (1) the Medicare costs report is (a) truthful, *i.e.*, that the cost information contained in the report is true and accurate; (b) correct, *i.e.*, that the hospital is entitled to reimbursement for the reported costs; and (c) complete, *i.e.*, that the cost report is based upon all cost information known to the hospital; and (2) the services identified in the cost report are billed in compliance with the law.

18. Furthermore, the hospital has the legal obligation to disclose to Medicare through its fiscal intermediary all known errors and omissions in its claims for Medicare reimbursement, including those costs identified in its cost reports:

> Whoever . . . having knowledge of the occurrence of any event affecting (A) [a hospital's] initial or continued right to any such benefit or payment . . . conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized . . . shall in the case of such a . . . concealment or failure . . . be guilty of a felony . . .

42 U.S.C. § 1320a7b(a)(3).

19. At all relevant times, WMC was required to and did submit its annual Medicare cost reports to the government through the fiscal intermediary.

20. At all relevant times, WMC was required to and did certify its annual Medicare cost reports.

II. The False Claims Act, The Anti-Kickback Statute, And The Stark Law

21. The FCA establishes liability to the United States for any person who "knowingly presents, or causes to be presented, to an officer or employee of the United States Government . . . a false or fraudulent claim for payment or approval," 31 U.S.C. § 3729(a)(1), or "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim," §3729(a)(1)(B). "Knowingly" is defined to include actual knowledge,

reckless disregard, and deliberate indifference. § 3729(b). No proof of specific intent to defraud is required. *Id.*

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

23. The AKS arose out of congressional concern that remuneration given to those who can influence health care decisions would result in goods and services being provided that are medically unnecessary, of poor quality, or even harmful to a vulnerable patient population. To protect the Medicare and Medicaid programs, among other federal healthcare programs, from these harms, Congress enacted a prohibition against the payment of kickbacks in any form. First enacted in 1972, Congress strengthened the statute in 1977 and 1987 to ensure that kickbacks masquerading as legitimate transactions did not evade its reach. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, §§ 242(b) and (c); 42 U.S.C. § 1320a-7b, Medicare-Medicaid Antifraud and Abuse Amendments, Pub. L. No. 95-142; Medicare and Medicaid Patient Program Protection Act of 1987, Pub. L. No. 100-93.

24. The AKS makes it illegal for individuals or entities to knowingly and willfully "offer[] or pay[] remuneration (including any kickback, bribe, or rebate) . . . to any person to induce such person . . . to purchase, . . . order, . . . or recommend purchasing . . . or ordering any good . . . or item for which payment may be made in whole or in part under a Federal health care program." 42 U.S.C. § 1320a-7b(b)(2). Violation of the AKS is a felony punishable by fines and imprisonment and can also result in exclusion from participation in federal health care programs. 42 U.S.C. § 1320a-7b(b)(2); 42 U.S.C. § 1320a-7(b)(7).

25. Compliance with the AKS, 42 U.S.C. § 1320a-7b(b), is a condition of payment under the federal health care programs.

26. As set forth in paragraphs 39 through 61, by providing kickbacks to physicians to induce them to refer patients to WMC, WMC has caused false claims to be submitted to the federal health care programs.

27. The Stark Statute, 42 U.S.C. § 1395nn, prohibits a hospital (or other entity providing healthcare items or services) from submitting Medicare and Medicaid claims for payment based on patient referrals from physicians having a "financial relationship" (as defined in the statute) with the hospital. The regulations implementing 42 U.S.C. § 1395nn expressly require that any entity collecting payment for a healthcare service "performed under a prohibited referral must refund all collected amounts on a timely basis." 42 C.F.R. § 411.353.

28. The Stark Law establishes the clear rule that the government will not pay for certain designated health services ("DHS") prescribed by physicians who have improper financial relationships with other providers. Congress found that financial relationships between physicians and entities to whom they refer patients can compromise the physicians' professional judgment as to whether a service is medically necessary, safe, effective, and of good quality. Congress relied upon various academic studies consistently showing that physicians who had financial relationships with hospitals and other entities ordered more of those entities' services than physicians without those financial relationships. The Stark Law was designed specifically to reduce the loss suffered by the Medicare and Medicaid programs due to such questionable overutilization of services.

29. DHS include: (1) clinical laboratory services; (2) physical therapy services; (3) occupational therapy services; (4) radiology services, including magnetic resonance imaging,

computerized axial tomography scans, and ultrasound services; (5) radiation therapy services and supplies; (6) durable medical equipment and supplies; (7) parenteral and enteral nutrients, equipment, and supplies; (8) prosthetics, orthotics, and prosthetic devices and supplies; (9) home health services; (10) outpatient prescription drugs; (11) inpatient and outpatient hospital services; and (12) outpatient speech-language pathology services. *See* 42 U.S.C. § 1395nn; 42 C.F.R. § 411.351. In essence, DHS constitute the vast majority of patient care services offered by hospitals.

30. In pertinent part, the Stark Statute provides:

> (a) Prohibition of certain referrals
>
> (1) In general
>
> Except as provided in subsection (b) of this section, if a physician (or immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2) then –
>
> (A) <u>the physician may not make a referral to the entity</u> for the furnishing of designated health services for which payment otherwise may be made under this subchapter,
>
> (B) <u>the entity may not present or cause to be presented a claim under this subchapter or bill</u> to any individual, third-party payor, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A).

42 U.S.C. § 1395nn (emphasis added).

31. The Stark Law broadly defines prohibited financial relationships to include any compensation paid directly or indirectly to a referring physician, subject to certain exceptions not applicable in this case. The financial relationships that trigger the prohibition on referrals include any ownership or investment interest in the entity as well as any compensation arrangement with the entity, unless an exception applies. 42 C.F.R. § 411.354. A "compensation arrangement," in turn, can be "any arrangement involving remuneration, direct or

indirect, between a physician . . . and an entity." *Id.* at § 411.354(c).

32. A "referral" means a request by a physician for an item or service for which a payment may be made under Medicare, including a request for consultation (including any tests or procedures ordered or performed by the consulting physician or under the supervision of the consulting physician), and the request or establishment of a plan of care by a physician that includes the furnishing of DHS (with certain exceptions for consultations by pathologists, diagnostic radiologists, and radiation oncologists). *See* 42 U.S.C. § 1395nn(h)(5).

33. Remuneration means any payment or other benefits made directly or indirectly, overtly or covertly, in cash or in kind. 42 C.F.R. § 351. Remuneration can include items such as rent, use of personal services of residents or fellows, or use of space and equipment.

34. "A direct financial relationship exists if remuneration passes between the referring physician . . . and the entity furnishing DHS without any intervening persons or entities between the entity furnishing DHS and the referring physician . . . ." 42 C.F.R. § 411.354(a)(2)(i).

35. An indirect compensation arrangement exists if the following elements are met:

(a) There is an unbroken chain between the referring physician and hospital providing DHS where there is either an ownership/investment interest or a compensation arrangement between each link;

(b) The referring physician's aggregate compensation varies with, or takes into account, the "volume or value" of referrals or other business generated by the referring physician for the hospital providing DHS; and

(c) The hospital knows or recklessly disregards or deliberately ignores the fact that the compensation arrangement varies with, or takes into account, the "volume value" of referrals or other business generated by the referring

physician for the hospital.

See 42 C.F.R. §411.354(c)(2).

36. CMS has interpreted "volume or value" under section 1887 of the Social Security Act "to establish a straightforward test that compensation arrangements should be at fair market value for the work or service performed or the equipment or space leased." Phase II, 69 F.R. 16068; Phase I, 66 F.R. 877.

37. The Stark Law prohibits the billing of DHS provided as a result of a prohibited referral. *See* 42 C.F.R. § 411.353(b). An entity that receives a prohibited referral may not present a claim, or cause the presentation of such claim to Medicare or Medicaid for reimbursement of the services. *See id.*

38. As set forth in paragraphs 39 through 61, by billing for DHS resulting from referrals from an entity with which WMC had a prohibited financial relationship, WMC has caused false claims to be submitted to the federal health care programs.

III. WMC's Financial Relationship With CCW Violated The AKS And The Stark Law

39. During all relevant times, CCW had a practice located at or near WMC's campus in Valhalla, New York.

40. CCW was a significant referral source for WMC. At times relevant to the complaint, CCW was responsible for approximately 80% of the cardiac referrals to WMC.

a. The Kingston Practice

41. In or around 2001, WMC asked CCW to set up a practice in Kingston, New York, so that CCW could expand its referral base and draw patients from the counties north of Westchester County.

42. CCW did not want to pay to set up the practice because it was concerned the

practice would not be profitable. As a result, WMC offered to finance and manage the set-up of CCW's Kingston practice with the understanding that CCW would "push down" patients to WMC.

43. To provide this financial and management support, WMC created Matrix Resources, L.L.C. ("Matrix").

44. On July 1, 2001, Matrix entered into a Management Agreement with CCW for a three-year term pursuant to which Matrix would deal with the day-to-day operations of setting up the office and would receive a management fee of $36,000 per year. Under the Management Agreement, Matrix's fee would increase to $86,000 per year if gross receipts exceeded $2,000,000 per year.

45. Matrix advanced funds to CCW to meet the costs of the practice by depositing funds into the Kingston Practice Account. Matrix also advanced the cost of its own management to CCW.

46. The Management Agreement required CCW to repay the advances with interest at a rate of 8.5% per year, computed from the date of the advance to the date of repayment. All payments were due by the end of the three-year term. The Management Agreement could, however, be renewed for an additional term of one year if, at the end of the initial term, Matrix had not been repaid for all advances plus interest. Additionally, CCW could terminate the Management Agreement after one year if the advances had been fully repaid.

47. In or around July 2001, CCW opened an office in Kingston, New York, with financial and administrative support from WMC. CCW began regularly referring patients to WMC for various services, including cardiac catheterization cases and coronary artery bypass graft ("CABG") surgeries.

48. WMC and CCW terminated the Management Agreement in August 2002. By that time, Matrix had advanced CCW $450,000, none of which had been repaid.

49. CCW viewed the advances as "seed monies" for the establishment of the Kingston practice and did not believe that it should have to pay the advances back. CCW informed WMC that, at a minimum, given the volume of patient referrals CCW was making from the Kingston practice to WMC and because WMC could expect the referrals to increase over time, the interest rate on the advances should be reduced and the payments should be spread over time. In a July 2002 memorandum to WMC concerning the modification of the Management Agreement, CCW pointed out that "Kingston is indeed successful, with likelihood of 200 cardiac cath cases, probably 50-75 CABG referrals over next year" and that "[i]t would not be unrealistic to expect 300 cases and 100 CABG patients yearly by 2005."

50. In or around April 2003, WMC and CCW agreed that CCW would pay back the advances over the course of five years at the interest rate of 4.75%. At the same time, however, WMC and CCW entered into a purported consulting agreement, dated April 25, 2003, that was made retroactively effective to July 2, 2002, pursuant to which WMC agreed to pay CCW $50,000 per year. CCW was required to provide WMC with written semi-annual reports regarding the progress of the services to be provided under the agreement.

51. In May 2003, WMC paid CCW a lump sum of over $40,000 for work purportedly done over the previous ten months and, from 2003 to 2004, WMC paid CCW a total of $102,000 under the agreement. The CCW physicians who were purportedly tasked with performing the services were not aware of having provided any services under the agreement. Neither CCW nor WMC have any records of work performed by CCW pursuant to the purported consulting agreement.

52. WMC received hundreds of referrals as a result of the Kingston practice. CCW carefully tracked the Kingston referrals and discussed with WMC the value of these referrals to WMC.

b. Contrary to WMC's Regular Practice Vis-à-vis Other Practices, WMC Allowed CCW to Use WMC's Fellows Free of Charge from 2002-2007

53. WMC and NYMC have had a decades-long relationship whereby NYMC supplies physicians, residents, and fellows to the hospital. During the relevant time period, many of the physicians who worked in WMC had faculty appointments at NYMC and supervised and taught residents and fellows who worked at WMC. Some of the physicians staffed various departments in WMC and also had their own private practices.

54. Generally, the residents and fellows performed work in the hospital such as patient exams and consultations. The private practices whose patients the residents and fellows treated billed Medicare for the work of the residents and fellows.

55. Cardiology fellows also spent approximately one month per year working off of the hospital campus at CCW's private offices. The fellows spent a majority of their time at the private offices administering nuclear stress tests and CCW billed Medicare for nuclear stress tests administered by fellows.

56. From July 1997 through July 2002, WMC billed CCW and CCW paid WMC $735,444.71 for its use of WMC's fellows. From August 2002 through at least March 2007, WMC sent bills to CCW but CCW did not make any payments to WMC even though it continued to use the fellows for the same type of work the fellows performed from July 1997 through July 2002.

57. As of March 25, 2007, CCW owed WMC over $700,000 for its use of WMC's fellows. WMC made no efforts to collect any of that amount from CCW other than the initial

bills sent to CCW. WMC continued to accrue the unpaid amounts in its accounts receivable and eventually wrote off the amount due. During that same time period, WMC billed and collected from other practices for their use of fellows.

c. WMC Was Aware of the Requirements and Limitations of the AKS and the Stark Law

58. In correspondence from WMC to CCW and other practice groups dating back to 1996, WMC referenced the Stark Law and its requirements and was plainly aware of the types of financial relationships prohibited under the Stark Law. For example, aware that it could not provide remuneration to CCW and other practice groups to induce referrals, WMC stated in a March 1996 memorandum to CCW concerning a license agreement for office space that "[t]his license agreement was developed in consideration of the Fraud and Abuse regulations that must be followed in space agreements between hospitals and physicians" and that "these types of agreements . . . must be arms['] length; at fair market value; be for at least one year; be inclusive of a share of common areas; and avoid any issues that could potentially be linked to referrals."

d. The Financial Arrangements between WMC and CCW Regarding the Kingston Practice and the Fellows Violated the AKS and the Stark Law

59. WMC's provision of "seed monies" to allow CCW to establish the Kingston practice and payment of money to CCW under a no-work consulting agreement at the same time CCW was required to pay back the "seed monies" was remuneration to induce CCW to refer patients from the Kingston practice to WMC. This conduct was in violation of the AKS. Likewise, WMC's provision of fellows to CCW for CCW to use in its private practice for nearly five years without requiring CCW to pay for its use of fellows—as it had during the previous five years and as other practices continued to do—was remuneration used to induce referrals in violation of the AKS.

60. WMC violated the Stark Law by billing for DHS resulting from CCW referrals. First, during the relevant time period, from 2001 through 2007, there was an unbroken chain of financial relationships between WMC, CCW, and the referring CCW physicians: WMC and CCW shared a compensation arrangement, and the CCW shareholder physicians had an ownership interest in CCW. Second, the aggregate compensation from WMC to CCW took into account the "volume or value" of referrals as follows: (a) WMC paid CCW nearly $102,000 pursuant to a consulting agreement under which CCW performed no work; and (b) WMC did not collect over $700,000 that CCW owed WMC for CCW's use of fellows even though CCW had previously paid for fellows and other practice groups continued to pay for fellows during the time period that CCW did not.

61. During the time relevant to this complaint, WMC illegally submitted hundreds of claims for services rendered to patients referred to WMC by CCW shareholders and obtained millions of dollars in Medicare reimbursements.

IV. WMC Sought And Obtained Reimbursements From Medicare For Costs It Did Not Incur And Which Were Not Reimbursable Under The Relevant Cost Reporting Rules

62. In general, Medicare pays a share of the costs associated with DGME and IME, *i.e*, the costs of residents and fellows. Subject to certain exceptions, however, Medicare does not pay for costs associated with the time the residents and fellows spend in non-hospital settings. If a resident or fellow spends time in more than one hospital or in a non-hospital setting, the hospital seeking reimbursement from Medicare may only seek reimbursement for the proportion of time the resident or fellow worked at that hospital. *See* 42 C.F.R. § 413.78(b).

63. Certain residents and fellows who worked at WMC spent rotations each year in non-hospital settings, such as private practices or clinical settings off hospital grounds.

64. WMC failed to carve out the time residents and fellows spent in non-hospital settings from the cost reports WMC submitted to Medicare.

65. By failing to carve out this time from the costs reports, WMC wrongly inflated its Medicare reimbursement for DGME and IME, and the United States, through the Medicare Program, paid WMC millions of dollars for these false or fraudulent claims. The United States, through the Medicare Program, would not have approved or paid such costs if it had known that such costs had been wrongfully included on WMC's cost reports.

FIRST COUNT

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

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

67. The United Sates seeks relief against WMC under Section 3729(a)(1) of the False Claims Act, 31 U.S.C. §3729(a)(1).

68. As a result of WMC's kickbacks to induce CCW to refer patients to WMC in violation of the federal Anti-Kickback Statute, 42 U.S.C. §1320a-7b(b)(2), and WMC's improper financial relationship with CCW in violation of the Stark Statute, 42 U.S.C. § 1395nn, and its implementing regulations, 42 C.F.R. § 411.350 *et seq.*, WMC knowingly caused to be presented false or fraudulent claims for payment or approval in violation of 31 U.S.C. § 3729(a)(1).

69. By reason of the false and fraudulent claims that WMC knowingly presented to Medicare, the United States has been damaged in a substantial amount to be determined at trial, and is entitled to treble damages plus a civil monetary penalty for each false claim.

SECOND COUNT

Violations of the False Claims Act: Use of False Statements (31 U.S.C. § 3729(a)(2)(2006), and, as amended, 31 U.S.C. § 3729(a)(1)(B))

70. The United States incorporates by reference paragraphs 1 through 65 as if fully set forth in this paragraph.

71. The United States seeks relief against WMC under the False Claims Act, 31 U.S.C. § 3729(a)(2)(2006), and, as amended, 31 U.S.C. §3729(a)(1)(B).

72. As a result of WMC's kickbacks to induce CCW to refer patients to WMC in violation of the federal Anti-Kickback Statute, 42 U.S.C. §1320a-7b(b)(2), and WMC's improper financial relationship with CCW in violation of the Stark Statute, 42 U.S.C. § 1395nn, and its implementing regulations, 42 C.F.R. § 411.350 *et seq.*, WMC knowingly, or acting in deliberate ignorance or in reckless disregard for the truth, made, used, or caused to be made or used, false records and statements material to false or fraudulent claims under the Medicare Program.

73. By reason of these false records or statements, the United States has sustained damages in a substantial amount to be determined at trial, and is entitled to treble damages plus a civil monetary penalty for each false claim.

THIRD COUNT

Unjust Enrichment

74. The United States incorporates by reference paragraphs 1 through 65 as if fully set forth in this paragraph.

75. As set forth above, the United States issued Medicare reimbursements to WMC in connection with referrals from CCW and non-reimbursable costs included in cost reports based on false or fraudulent claims. The circumstances of WMC's receipt of payments based on these false and fraudulent claims are such that, in equity and good conscience, WMC should not retain

those payments, the amount of which is to be determined at trial.

FOURTH COUNT

Payment By Mistake

76. The United States incorporates by reference paragraphs 1 through 65 as if fully set forth in this paragraph.

77. The United States seeks relief against WMC to recover the Medicare reimbursements obtained by WMC in connection with referrals from CCW and non-reimbursable costs included in cost reports, which were paid under the erroneous belief that WMC was entitled to such payments.

78. Under such circumstances, the United States' payment of federal funds under the Medicare Program was by mistake and was not authorized. WMC, accordingly, is liable to account for and repay such funds, the amount of which is to be determined at trial, to the United States.

FIFTH COUNT

Common Law Fraud

79. The United States incorporates by reference paragraphs 1 through 65 as if fully set forth in this paragraph.

80. WMC made material misrepresentations of fact, with knowledge of, or in reckless disregard of, their truth, in connection with the claims for reimbursement submitted by, or on behalf of, WMC under the Medicare Program. Specifically, WMC certified in its cost reports submitted to the Medicare Program that it was in compliance with the laws and regulations regarding the provision of healthcare services, including the Anti-Kickback Statute, 42 U.S.C. §1320a-7b(b)(2), and the Stark Statute, 42 U.S.C. § 1395nn, and its implementing regulations, 42

C.F.R. § 411.350 *et seq.*, when it was not. Additionally, WMC sought reimbursement for costs it did not incur through the costs reports WMC submitted to Medicare.

81. WMC intended that the United States rely upon the accuracy of the false representations referenced above.

82. The United States made substantial payments of money in justifiable reliance upon WMC's false representations.

83. WMC's actions caused the United States to be damaged in a substantial amount to be determined at trial.

WHEREFORE, the United States respectfully requests judgment against WMC as follows:

a. On the First and Second Claims for relief (False Claims Act), a judgment awarding treble the Government's damages in an amount to be determined at trial, such civil penalties under the False Claims Act as are required by law, and costs pursuant to 31 U.S.C. § 3729(a)(1)(A) and (a)(1)(B);

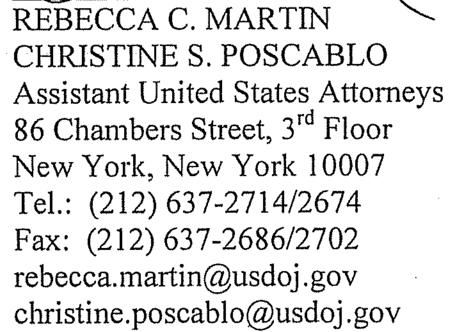
b. On the Third, Fourth, and Fifth Claims for relief (common law), a judgment for damages in an amount to be determined at trial, together with costs and interest; and

c. Such further relief as is proper.

Dated: New York, New York
May 13, 2015

PREET BHARARA
United States Attorney for the
Southern District of New York

Attorney for the United States of America



By: ______________________

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