UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

UNITED STATES OF AMERICA *ex rel.* BRANDEE WHITE, LAURA L. CUNNINGHAM, AND JEFFREY M. WISLER,	:	CIVIL ACTION NO. 1:15-cv-555
	:	Judge Susan J. Dlott
Plaintiffs,	:	Mag. Karen L. Litkovitz
v.	:	
MOBILE CARE EMS & TRANSPORT, INC.,	:	
Defendant.	:	

UNITED STATES' COMPLAINT-IN-PARTIAL-INTERVENTION AND DEMAND FOR A JURY TRIAL

This is a civil fraud action brought by the United States of America ("United States" or "Government") to recover treble damages and civil penalties under the False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733, as well as for restitution and common law damages, for monies unlawfully obtained and/or retained from the federal Medicare Program by Mobile Care EMS & Transport, Inc. ("Mobile Care" or the "Defendant"). Having contemporaneously filed a notice of intervention pursuant to 31 U.S.C. § 3730(b)(3), the United States alleges for its complaint-in-partial-intervention (the "Government's Complaint" or the "Complaint") as follows.

INTRODUCTION

1. The United States brings this False Claims Act action against Mobile Care to recover losses sustained by Medicare and Medicaid (together, the "Government Healthcare Programs"). Medicare is a federally-funded program that provides medical insurance for certain items and services to qualified individuals. In addition to paying for doctor visits, nursing home care, and hospital stays, Medicare offers a transportation benefit for eligible Medicare beneficiaries.

2. The United States alleges that Mobile Care focused on maximizing Medicare reimbursement for as many patients' transportation as possible while disregarding patients' medical needs and Medicare guidelines when providing ambulance transportation.

3. Specifically, since at least December 2009, Mobile Care submitted or caused the submission of false claims to the Government Healthcare Programs by billing those programs for more costly transportation services using stretchers when its patients were ambulatory and had no need for stretcher transport. Mobile Care also submitted or caused to be submitted fraudulent records and statements in support of their false claims for payment to the Government healthcare programs.

4. Mobile Care regularly ignored concerns expressed by its own employees, including Relators, that it was providing higher levels of ambulance care than was medically necessary.

5. As a result of this conduct, Mobile Care is liable under the False Claims Act, 31 U.S.C. § 3729, *et seq*.

JURISDICTION AND VENUE

6. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1345 because the United States is the Plaintiff. In addition, the Court has subject matter jurisdiction over the FCA claims for relief under 28 U.S.C. §§ 1331 and 1345 and 31 U.S.C. § 3732(a)-(b) and supplemental jurisdiction to entertain the common law and equitable claims for relief under 28 U.S.C. § 1367(a).

7. This Court has personal jurisdiction over the Defendant pursuant to 31 U.S.C. § 3732(a) because the Defendant can be found in, resides in, transacts business in, or has committed the alleged acts in the Southern District of Ohio and the United States.

8. Venue also lies in this District pursuant to 28 U.S.C. § 1391(b)-(c) and 31 U.S.C. § 3732(a) because the Defendant, with a principal place of business at 5151 Main Street, Sylvania, Ohio 43560 can be found in, resides in, or transacts business in this District, a substantial part of the events or omissions giving rise to the claims occurred in this District, and/or the Defendant is subject to the Court's personal jurisdiction under the FCA.

PARTIES

I. Plaintiffs

9. Plaintiff is the United States of America, suing on behalf of the United States Department of Health and Human Services ("HHS"), which includes its operating division, the Centers for Medicare and Medicaid Services ("CMS"). At all times relevant to this Complaint, CMS administered and supervised the Medicare Program. The United States filed its notice of partial intervention in this action on November 16, 2018.

10. The *qui tam* plaintiffs ("Relators") are Brandee White, Laura L. Cunningham, and Jeffrey M. Wisler, all current or former employees of Mobile Care. Relator White is a former

Emergency Medical Technician ("EMT") and EMT manager. Relator Cunningham was hired by Mobile Care in March 2014 as an ambulance biller. Relator Wisler is a nationally certified paramedic and was hired by Mobile in April 2013 and presently works as an EMT.

II. Defendant

11. Defendant Mobile Care EMS & Transport, Inc. is an Ohio corporation that does business in the State of Ohio. Its principal office is at 5151 S. Main St., Sylvania, Ohio 43560. Mobile Care is a participant in the Government healthcare programs. At all times relevant to the Complaint, Mobile Care either directly or through its subsidiaries and agents, provided emergency and nonemergency transportation for beneficiaries of Government healthcare programs in Ohio.

THE LAW

I. The False Claims Act

12. Congress amended the False Claims Act, 31 U.S.C. §§ 3729-3733, via the Fraud Enforcement and Recovery Act of 2009 ("FERA"), P.L. 111-21, § 4(f), 123 Stat. 1621. FERA, at 123 Stat. 1625, provides: "The amendments made by this section [amending 31 U.S.C. §§ 3729-3733] shall take effect on the date of enactment of this Act and shall apply to conduct on or after the date of enactment, except that (1) subparagraph (B) of section 3729(a)(1) of title 31, United States Code, as added by subsection (a)(1), shall take effect as if enacted on June 7, 2008, and apply to all claims under the False Claims Act (31 U.S.C. 3729 *et seq*.) that are pending on or after that date…."

The False Claims Act as amended by FERA provides, in pertinent part:

> (a) Liability for certain acts.
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> (1) In general. Subject to paragraph (2), any person who-(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or

> causes to be made or used, a false record or statement material to a false or fraudulent claim…. (G)…knowingly conceals or knowingly and improperly avoids…an obligation to pay or transmit money…to the Government…is liable to the United States Government….
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> (b) Definitions. For purposes of this section-
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> (1) the terms "knowing" and "knowingly" (A) mean that a person, with respect to information (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information; and (B) require no proof of specific intent to defraud;
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> (2) the term "claim" (A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that (i) is presented to an officer, employee, or agent of the United States; or (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government (I) provides or has provided any portion of the money or property requested or demanded; or (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

31 U.S.C. § 3729 (2010).

II. Government Healthcare Programs

A. Medicare

13. Title XVIII of the Social Security Act, 42 U.S.C. § 1395 - 1395ggg, establishes the Health Insurance for the Aged and Disabled Program, popularly known as the Medicare Program, or Medicare.

14. The Secretary of the Department of Health and Human Services ("HHS") has oversight authority for the Medicare Program.

15. The Secretary of HHS administers the Medicare Program through the Centers for Medicare and Medicaid Services ("CMS").

16. The Medicare Program is comprised of four parts: Part A, Part B, Part C and Part D.

17. Medicare Parts A, C and D are not directly at issue in this case.

18. Medicare Part B provides federal government funds to help pay for, among other things, patient transportations services.

19. Medicare Part B is funded by insurance premiums paid by enrolled Medicare beneficiaries and contributions from the federal treasury.

20. Eligible individuals, who are age 65 or older or disabled, may enroll in Part B to obtain benefits in return for payments of monthly premiums as established by HHS.

21. The Medicare Program often makes payments directly to service providers, such as transportation companies, rather than to the Medicare beneficiary, who is the patient.

22. The Medicare Program makes payments directly to providers when the beneficiary assigns to the provider, and the provider accepts assignment of, the right to payment.

23. When a beneficiary has assigned the right to payment to the provider, the provider may submit its bill directly to Medicare, rather than to the patient, for payment.

24. The United States provides reimbursement for Medicare claims through CMS.

25. A provider must sign a Medicare Provider Enrollment Agreement to participate in the Medicare Program.

26. When a provider signs a Medicare Provider Enrollment Agreement, the provider agrees to learn and adhere to Medicare and other federal health care program laws, regulations and Program instructions.

1. Medicare Conditions of Payment for Ambulance Transport

27. The Medicare Program requires complete compliance with Medicare and other federal health care program laws, regulations and Program instructions as a precondition of governmental payment.

28. The Provider Enrollment Agreement states, "I understand the payment of a claim by Medicare or other federal health care programs is conditioned on the claim and the underlying transaction complying with such laws, regulations and program instructions…."

29. All healthcare providers, including transportation providers, must comply with applicable statutes, regulations and guidelines in order to be reimbursed by Medicare Part B.

30. The Medicare Program covers only reasonable and necessary medical services. 42 U.S.C. § 1395y(a)(1)(A).

31. Indeed, providers have a duty to provide services only when they are medically necessary. 42 U.S.C. § 1320c-5(a)(1).

32. Medicare regulations exclude from payment services that are not reasonable and necessary. 42 C.F.R. § 411.15(k)(1).

33. In order to bill the Medicare Part B Program, a transportation company must submit a hard-copy claim form called CMS 1500, or an electronic equivalent. 42 C.F.R. § 424.32.

34. Medicare requires compliance with the terms on the claim form as a precondition of Governmental payment.

35. When the provider submits the claim form, the provider certifies that the services in question were "medically indicated and necessary for the health of the patient" and "were personally furnished by me."

36. The claim form states, "No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations."

37. On a claim form, a provider must state, among other things, the procedure(s) for which he is billing Medicare.

38. At all times relevant to this Complaint, Mobile Care was a participating provider with the Medicare Program.

39. Mobile Care submits claims to Medicare using an electronic version of the CMS 1500 submission form.

40. During the time period December 2009 through 2015, Medicare paid Mobile Care approximately $5.6 million in medical and health care payments for approximately 24,000 claims. During that same period, Medicaid provided approximately $1.1 million in reimbursement.

41. Mobile Care also sought reimbursement from other Government healthcare programs, including Medicare Part A, Medicare Advantage, Medicaid, MyCare Ohio and TRICARE, but the majority of the claims, and those at issues in this Complaint, were submitted to Medicare Part B.

42. The top five paid procedure codes from services Mobile Care billed between 2009 and 2015 were: ambulance service, basic life support (non-emergency transport); ambulance service, advanced life support (emergency transport); ambulance service, basic life support (emergency transport); ground mileage; and ambulance service, advanced life support (non-emergency service).

a. Medical Necessity Is Required to Bill Medicare for Ambulance Transportation and for the Level of Service Provided

43. The Medicare Part B Program pays for ambulance services only if they meet Medicare's standard of medical necessity. 42 U.S.C. § 1395x(s)(7). By statute, that medical necessity standard is met "where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations." *Id.*

44. The regulations applicable to claims processed during the period at issue in this Complaint state that Medicare would pay for ambulance transportation only if "[o]ther means of transportation would endanger the beneficiary's health." 42 C.F.R. § 410.40 (1994).

45. The Medicare Carriers Manual ("MCM") Part 3, § 2125 provides that this regulatory requirement was presumptively met if the medical evidence showed a beneficiary required oxygen during transport, required movement by a stretcher, or was transported in an emergency situation, for example, as a result of accident, injury, or acute illness.

b. Medical Necessity for Ambulance Transportation

46. Ambulance service providers must always keep appropriate documentation on file to demonstrate medical necessity, and "[t]he presence of a signed physician certification statement does not alone demonstrate that the ambulance transport was medically necessary." Rather, "[a]ll other program criteria must be met in order for payment to be made." 42 C.F.R. §§ 410.40(d)(2)(ii), 410.40(d)(3)(v); *accord* Medicare Benefit Policy Manual, CMS Pub. 100-02, Chap. 10-Ambulance Services, Secs.10.2.1 (Rev. 1, Oct. 1, 2003) & 10.2.4.

47. Nonemergency ambulance transport is considered medically necessary only if either: "the beneficiary is bed-confined, and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or, if his or her medical condition,

regardless of bed confinement, is such that transportation by ambulance is medically required." 42 C.F.R. § 410.40(d)(1).

48. A Medicare beneficiary is "bed confined" if the beneficiary "is unable to get up from bed without assistance," "is unable to ambulate," and "is unable to sit in a chair or wheelchair." 42 C.F.R. § 410.40(d)(1)(i)-(iii). As explained in the Medicare Benefit Policy Manual: "The term 'bed confined' is not synonymous with 'bed rest' or 'non-ambulatory.' Bed-confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicare ambulance benefits." Medicare Benefit Policy Manual, CMS Pub. 100-02, Chap. 10-Ambulance

Services, Sec. 10.2.3.

c. Medical Necessity for Nonemergency Transportation

49. Medicare covers repetitive nonemergency ambulance transportation only "if the ambulance provider or supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician [dated no earlier than 60 days before the date the service is furnished] certifying that the medical necessity requirements of paragraph (d)(1) of [42 C.F.R. § 410.40] are met." 42 C.F.R. § 410.40(d)(2)(i).

50. Medicare covers unscheduled ambulance services or services scheduled on a non-repetitive basis under the following circumstances:

> a. For a resident of a facility who is under the care of a physician, if the ambulance provider or supplier obtains a written order from the beneficiary's attending physician, within 48 hours after the transport, certifying that the medical necessity requirements of paragraph (d)(1) of this section are met.
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> b. For a beneficiary residing at home or in a facility who is not under the direct care of a physician, physician certification is not required.

> c. If the ambulance provider or supplier is unable to obtain a signed physician certification statement from the beneficiary's attending physician, a signed certification statement must be obtained from either the physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner, who has personal knowledge of the beneficiary's condition at the time the ambulance transport is ordered or the service is furnished. This individual must be employed by the beneficiary's attending physician or by the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported. Medicare regulations for PAs, NPs, and CNSs apply and all applicable State licensure laws apply; or,
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> d. If the ambulance provider or supplier is unable to obtain the required certification within 21 calendar days following the date of the service, the ambulance supplier must document its attempts to obtain the requested certification and may then submit the claim. Acceptable documentation includes a signed return receipt from the U.S. Postal Service or other similar service that evidences that the ambulance supplier attempted to obtain the required signature from the beneficiary's attending physician or [other person described in the preceding paragraph]. 42 C.F.R. § 410.40(d)(3).

51. Medicare covers ambulance transports if the destination is a hospital, a critical access hospital ("CAH"), a skilled nursing facility ("SNF"), a beneficiary's home, or a dialysis facility for an end stage renal disease ("ESRD") patient who requires dialysis. Medicare Benefit Policy Manual, CMS Pub. 100-02, Chap. 10-Ambulance Services, Sec. 10.3.

52. Medicare ambulance coverage is further limited to the following specific origins and destinations:

> (1) From any point of origin to the nearest hospital, CAH, or SNF that is capable of furnishing the required level and type of care for the beneficiary's illness or injury. The hospital or CAH must have available the type of physician or physician specialist needed to treat the beneficiary's condition.
> (2) From a hospital, CAH, or SNF to the beneficiary's home.
> (3) From a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident, including the return trip.

> (4) For a beneficiary who is receiving renal dialysis for treatment of ESRD, from the beneficiary's home to the nearest facility that furnishes renal dialysis, including the return trip.

42 C.F.R. § 410.40(e).

53. As a general rule, ambulance service to a physician's office is not covered by Medicare. Ambulance service to a physician's office is only covered if the ambulance transport is "enroute to a Medicare covered destination" and "[d]uring the transport, the ambulance stops at a physician's office because of the patient's dire need for professional attention, and immediately thereafter, the ambulance continues to the covered destination." Medicare Benefit Policy Manual, CMS Pub. 100-02, Chap. 10-Ambulance Services, Sec. 10.3.8.

B. Medicaid

54. The Medicaid program was established in 1965 pursuant to 42 U.S.C. §§1396, *et seq.* Medicaid is a joint federal and state program that provides healthcare benefits for certain groups, primarily the poor and disabled. Medicaid is jointly financed by the Federal Government and by the various state governments.

55. Pursuant to the Medicaid program, the Government provides funds to the states to provide medical assistance to individuals, including children and aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services. 42 U.S.C. § 1396-1. Funds for Medicaid are appropriated from the Treasury and are provided to the States. 42 U.S.C. §§ 1396-1, 1396b.

56. Though funded primarily by the Federal Government, Medicaid programs are administered by the individual states. *See* 42 U.S.C. § 1396a.

57. Each state establishes its own Medicaid program and determines the amount, duration, and scope of services covered within federal guidelines. States must cover certain mandatory benefits and may choose to provide other optional benefits.

58. Every provider who seeks payment from the federally-funded Ohio Medicaid Program is required to sign a Provider Agreement. *See* Ohio Administrative Code 5160-1-17(A)(4).

59. As part of that standard Provider Agreement, all providers agree, *inter alia*, to comply with federal statutes and rules and with the Ohio Administrative Code. The provider also explicitly certifies by signing the Provider Agreement that the provider will "render medical services as medically necessary for the patient and only in the amount required by the patient...." Ohio Administrative Code 5160-1-17.2(A).

60. In addition, all providers of ambulance services must be certified under and participating in Medicare pursuant to Ohio Medicaid requirements. Ohio Administrative Code 5160-15-02(B)(1). Accordingly, all providers of ground ambulance services under Ohio Medicaid must execute the standard Medicare Provider Agreement in which they agree to abide by all Medicare laws, regulations, and program instructions, and expressly acknowledge that the payment of claims by Medicare is conditioned upon the claim and the underlying transaction complying with those laws, regulations and program instructions and the provider's compliance with all applicable conditions of participation in Medicare. *See* Form CMS-855B.

1. Medicaid Conditions of Payment for Transport of Patients

61. Medicaid will reimburse for ambulance transportation provided to Medicaid beneficiaries who are eligible for services at the time of transport. Ohio Administrative Code 5160-15-01(A)(17)-(18), 15-03(A), 15-03(E)(15).

62. If the patient is a beneficiary of both the Medicare and Medicaid programs, then Medicare will be the primary payor and Medicaid will only reimburse co-insurance and deductible amounts. Ohio Administrative Code 5160-15-03(A)(2)(j).

63. Medicaid covers only medically necessary services. Ohio Administrative Code 5160-15-03(A)(2)(a).

64. For nonemergency transport, ambulance services are medically necessary when, based on the patient's condition at the time of transport, one of the following descriptions is satisfied:

> (a) An individual is nonambulatory and unable to use an ambulette because the individual is unable to get up from bed without assistance; the patient is unable to sit in a chair or wheelchair; and can only be moved only by a stretcher and/or needs to be restrained; or
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> (b) An individual is not in a life-threatening situation, but requires continuous medical supervision or treatment during the transport; or
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> (c) An individual. . . requires oxygen administration during the transport, and the patient is unable to self-administer or self regulate the oxygen or the patient requiring oxygen administration has been discharged from a hospital to a nursing facility.

Ohio Administrative Code 5160-15-03(A)(2)(a)(i), (A)(2)(a)(iii)(a)–(c).

65. For purposes of this rule, a person is "nonambulatory" if he or she has "permanently or temporarily disabling conditions which preclude transportation in motor vehicle(s) or motor carriers as defined in section 4919.75 of the Revised Code that are not modified or created for transporting a person with a disabling condition. The permanently or temporarily disabling conditions must require transport by air ambulance, ambulance or

ambulette (for example, patients requiring stretcher transportation or wheelchair-bound individuals) in accordance with this rule." Ohio Administrative Code 5160-15-01(A)(20).

66. Unless one of the above criteria is met, nonemergency transportation of patients who are ambulatory at the time of transport is not covered by Ohio Medicaid. Ohio Administrative Code 5160-15-03(E)(8).

67. Ohio Medicaid covers ambulance transport if the transport is either to a "Medicaid covered service" or from a "Medicaid covered service," as that term is defined at Ohio Administrative Code 5160-15-01(A)(17). Ohio Administrative Code 5160-15-03(A)(2)(c) (referencing Ohio Administrative Code 5101:3, which was renumbered 5160-15-01, eff. Oct. 1, 2013).

68. Ohio Medicaid covers ambulance services only if the service is provided from a Medicaid covered point of transport, unless prior authorization is obtained. Ohio Administrative Code 5160-15-03(A)(2)(d), 15-03(D).

69. Furthermore, an ambulance provider can bill Ohio Medicaid for ambulance transportation only if Medicaid's documentation requirements are satisfied. Ohio Administrative Code 5160-15-02(E). Among other requirements, "ambulance and ambulette services must maintain records which fully describe the extent of services provided," and specified documentation must be obtained and maintained by the ambulance provider's billing department before Ohio Medicaid is billed. Ohio Administrative Code 5160-15-02(E)(1).

70. In addition, Ohio Medicaid will not pay for nonemergency ambulance transport unless, before the claim is filed, a medical practitioner completes a "Practitioner Certification Form" certifying that the ambulance service is medically necessary (with some enumerated exceptions). Ohio Administrative Code 5160-15-02(E)(4).

FACTUAL ALLEGATIONS

I. MOBILE CARE PRESENTED OR CAUSED THE PRESENTATION OF FALSE CLAIMS TO GOVERNMENT HEALTHCARE PROGRAMS

71. Beginning in approximately December 2009 and continuing to the present, Mobile Care knowingly presented or caused the presentation of false or fraudulent claims to Government healthcare programs, and made or caused to be made false records and statements to get claims for ambulance services to Government healthcare programs paid.

72. Mobile Care billed Government healthcare programs for ambulance transport when no medical necessity was present or documented.

73. After Relator White began training employees concerning the applicable legal requirements, Mobile Care pressured its employees to create false documentation to support false claims, or to submit false claims unsupported by any documentation—all with the end result of billing the Government for expensive ambulance transportation that was medically unnecessary or that was upcoded to a higher charge for no medically necessary reason.

A. Efforts to Stop Mobile Care's Improper Billing Were Unsuccessful

74. When Relator White was hired in February 2014, Mobile Care's billers told Relator White that they did not have a copy of the applicable Medicare ambulance regulations.

75. At the time of her hiring, Relator White discovered that Mobile Care's Patient Care Reports for nonemergency transportation routinely lacked details regarding the patient and routinely lacked any information demonstrating that the patients had the medical necessity required to bill Government healthcare programs for ambulance transportation.

76. For example, Patient Care Reports for nonemergency transportation of patients to dialysis clinics typically stated that the patient was picked up at their facility, was put on a

stretcher, was taken to the dialysis facility, and was transferred to the dialysis nurse. This description does not demonstrate medical necessity for ambulance transport.

77. As the Mobile Care employee responsible for ensuring compliance with the law and for compliance training, Relator Brandee White made numerous efforts to train Mobile Care's officers, employees, and managers in proper ambulance documentation and billing procedures.

78. However, Mobile Care's other employees and managers continued to improperly bill Government healthcare programs for ambulance services that were not medically necessary or that otherwise did not meet requirements for billing Government healthcare programs for ambulance services.

79. Mobile Care knew what the law required, and nevertheless continued to submit false claims for ambulance services that lacked medical necessity or that otherwise did not meet the requirements for billing Government healthcare programs for ambulance services.

80. After Relator White began training Mobile Care's paramedics, EMTs, billers, and other employees concerning the requirement for medical necessity and other billing requirements of Government healthcare programs, Mobile Care began to lose money due to a reduction in its billings. In particular, after some of Mobile Care's dialysis patients were switched from ambulance transportation to ambulette van transportation, Mobile Care received reduced income.

81. Mobile Care understood that legal compliance would lead to reduced income. By email to Relator White dated April 29, 2015, Eric McAllister, Mobile Care's Director of Medical Transportation Services, informed Relator White that Mobile Care would not be 100% compliant with Medicare's requirements for ambulance billing, stating: "Again, I realize we cannot operate at 100% compliance as we will be out of business."

82. Then, demonstrating his knowledge that Mobile Care's false claims to Government healthcare programs violate the False Claim Act, in the same email Mr. McAllister states that too little compliance might be an issue because a whistleblower might file a False Claims Act suit seeking a reward: "However; if we are 80% or less that could cause harm to us also. We need to operate at the 80%-90% on EMS documentation/compliance. All that is needed is a disgruntled employee (whistleblower) to make some false claim. By the way; whistleblowers are entitled to a certain percentage of what is collected."

83. To illustrate his point, Mr. McAllister provided a link to a local newspaper article discussing a False Claims Act lawsuit filed by the Department of Justice against a long term care provider based in Toledo, Ohio.

84. After Relator White asked Mr. McAllister what he meant by his email, by reply of April 30, 2015, Mr. McAllister reiterated his belief that Mobile Care should continue to submit false claims, stating: "We need to be at 85-90% compliance regarding billing those runs. Not every single run will have every key detail in it, but on ones that are close, we need to bill, period."

85. In a meeting that occurred on approximately June 1, 2015, Joe Wallace announced to the Mobile Care Billing and Collections Staff (including both Relator White and Relator Cunningham), that Mobile Care would shoot for 80 to 90% compliance with Medicare's requirements for ambulance transport. At the same meeting, Joe Wallace announced Relator White's demotion and further announced Eric McAllister would take over Relator White's former management position for billing and billing compliance.

86. Relator White continued to insist that claims to Medicare for ambulance transport be billed to Government healthcare programs only if medical necessity both existed and was

documented, and also that all other payment requirements were satisfied. Mobile Care continued to lose money due to Relator White's insistence that Mobile Care's claims to Government healthcare programs comply with all program requirements, be truthful, and not be false.

87. Despite Relator White's continued efforts to stop Mobile Care's presentation of false claims for ambulance services, Mobile Care continued to present and cause the presentation of false claims for ambulance transportation to Government healthcare programs.

88. In retaliation for Relator White's efforts to stop Mobile Care's continued violations of the False Claims Act by bringing Mobile Care into compliance with prerequisite requirements for billing Government healthcare programs for ambulance services, Mobile Care retaliated against and demoted Relator White, and then eventually fired her on August 17, 2015.

B. Pressure Applied to Mobile Care Emergency Medicine Technicians

89. Mobile Care improperly and illegally directed its Emergency Medicine Technicians ("EMTs") who transport patients in ambulances to add specific statements and words to their Patient Care Reports. Mobile Care did this to create the impression that the patients had a medically necessary reason requiring them to be transported in an ambulance so that Mobile Care could improperly bill Government healthcare programs for ambulance transport.

90. Even when such words and phrases were insufficient to show medical necessity for ambulance transport, Mobile Care instructed its billers to submit such claims to Government healthcare programs for ambulance transportation anyway.

1. Summer 2014 Meeting

91. In the summer of 2014, Eric McAllister and Matt Miller, Mobile Care's EMS Operations Manager, held a mandatory meeting at a Mobile Care garage for all Mobile Care EMTs. Mobile Care owner Joe Wallace attended this meeting as well.

92. Relator Wisler and all of the other Mobile Care EMTs who attended the meeting were told by these Mobile Care managers to put the words "poor trunk control" in their Patient Care Reports for all dialysis patients regardless of their condition. The EMTs were told that this was needed for billing.

93. Notably, the phrase "poor trunk control" does not alone support medical necessity required to bill Medicare ambulance services because some such patients can be safely transported in a wheelchair. Some additional description of why the patient's "poor trunk control" makes them unable to be transported in a wheelchair is required.

2. April 2015 Meetings

94. Mobile Care instructed its paramedics and EMTs to attend one of two scheduled mandatory meetings on April 11 or April 18, 2015. Relator Wisler attended the April 18, 2015 meeting.

95. At the April 18, 2015 meeting, Mobile Care EMS Lieutenant Chad Jendrzejak told the paramedics and EMTs that when transporting patients on an emergency basis, every patient over the age of 50 should be hooked up to an IV and should have a cardiac monitor applied.

96. This blanket instruction is not appropriate because not every patient over the age of 50 medically requires this treatment.

97. For example, emergency patients with simple bone fractures do not necessarily need a cardiac monitor, even if they are over the age of 50. However, Mobile Care has monetary incentive to require its paramedics and EMTs to provide such care to every patient over 50. Hooking patients up to an IV and applying a cardiac monitor is an automatic upcode for billing purposes from Basic Life Support (BLS) to Advanced Life Support (ALS).

98. In addition, Mr. Jendrzejak told the paramedics and EMTs present at the April 18, 2015 meeting that they must supply a purpose for transporting patients on a stretcher to bill Medicare for transporting patients in their ambulances.

99. Regarding Mobile Care's profitable dialysis patients, Mr. Jendrzejak told the paramedics and EMTs to put a statement in their Patient Care Reports that these patients need ambulance transport due to history of stroke, diabetes, and hypertension.

100. Mr. Jendrzejak told the paramedics and EMTs to write this in their reports for every patient for every run, so that Medicare and Medicaid could be billed for ambulance transport.

101. In August 2015, one of Relator Wisler's colleagues failed to follow this directive and was instructed by Mr. Jendrzejak to amend a Patient Care Report to falsely state that the dialysis patient had a history of stroke (even though she knew that the patient had no history of stroke), so that the patient's transport could be billed to Medicare.

102. Furthermore, Mr. Jendrzejak reminded paramedics and EMTs that their paychecks and jobs depended on money coming in. A slide in his presentation states in part: "Remember, every run is essentially your pay check. If billing cannot send bills out so our collectors can collect it, money will not come in. If money doesn't come in, we are forced to make cuts, Period. Document what you see, find, hear and do etc... NEVER worry about billing, only concern yourselves with YOURSELF, Your Partner, and finally Your Patient. Billing will work itself out."

103. Even though Mr. Jendrzejak stated in this slide that paramedics and EMTs did not need to worry about billing, this was contradicted by the prior two sentences, which said that the

paramedics and EMTs would not get paid if the billing department could not submit bills to the Government that were supported by documentation.

104. Due to Mr. Jendrzejak's statements, the paramedics and EMTs understood that Mobile Care wanted them falsely to state that medical necessity for ambulance transport was present even when it was not.

105. Also at the April 18, 2015 meeting, these Mobile Care managers stated that ambulance transport of these dialysis patients is the bread and butter business (*i.e.* money-making business) of Mobile Care, and that Mobile Care cannot replace its failing patient care monitors and aging ambulances without this income.

106. Relator Wisler has been told by Mobile Care management that Mobile Care can earn up to $106,000.00 per year transporting one dialysis patient by ambulance. By contrast, Ohio Medicaid only pays on average $30.00 per trip to transport patients by ambulette in their wheelchairs, which equates to approximately $9,360.00 per year.

C. Pressure Applied to Mobile Care Billers

107. Mobile Care routinely pressured their billers, including Relator Cunningham, to submit all claims for ambulance transportation to Government healthcare programs for payment, even though no medical necessity justifying such claims was documented.

108. Chad Jendrzejak told Relator Cunningham that Mobile Care could not be 100% compliant with the requirements of Government healthcare programs for billing for ambulance transportation.

109. When Relator Cunningham refused to bill claims for ambulance transportation when the Patient Care Report shows no medical necessity, Eric McAllister instructed another

biller to submit those claims for payment for ambulance services to Government healthcare programs anyway.

110. In addition, Relator Cunningham and other Mobile Care billers are routinely pressured to bill Government healthcare programs when the Patient Care Reports for ambulance transport do not demonstrate medical necessity.

II. EXAMPLES

111. The following are examples of Mobile Care's presentation or causing the presentation of false claims to the United States Government for payment of ambulance services that did not meet the prerequisites conditions of payment for such claims.[1]

A. Example 1

112. On May 7, 2015, Patient 1 was transported by ambulance from a hospital in Ohio to a nursing facility in Ohio, where Patient 1 had just been treated for "Altered Mental Status." The Patient Care Report written by Mobile Care's EMT provided no medically necessary reason for the ambulance transport. Rather, the patient "rested comfortable" during the transport and "remained stable."

113. In her role as a Mobile Care biller, Relator Cunningham reviewed the EMT's Patient Care Report for this trip and observed no medical necessity justifying transport by ambulance. Relator Cunningham provided Relator White with this Patient Care Report for her review as Mobile Care's manager responsible for compliance.

114. Relator White emailed Matt Miller and Eric McAllister on May 8, 2015 regarding this transport. Mr. McAllister responded on May 11, 2015 that the EMT could correct the report

[1] The United States will supply detailed information identifying these claims to the Defendant, including patient name, HIC number, payer, claim number, procedure code, diagnosis code, date of service, date the claim was submitted, amount claimed, and amount paid, upon entry of an appropriate protective order.

by changing the report from stating that the patient is "on [oxygen]" so that it stated instead that the patient is "on [oxygen] . . . and cannot regulate their own [oxygen]."

115. The fact that a patient is on oxygen is not enough to create the medical necessity needed to bill Medicare for ambulance transport under Medicare regulation and guidance. But the fact that a patient is unable to regulate their oxygen may warrant ambulance transport.

116. Without taking any steps to verify whether Patient 1 actually was unable to regulate her own oxygen, Eric McAllister directed Mobile Care's information technology director to alter the patient's medical record in an email dated May 11, 2015, stating: "Any chance you can do this on the back end? If not, let me know and I will have Matt [Miller] advise John [the EMT] he needs to correct it. Simple fix, just delete the patient requires stretcher due to line and add something about patient not being able to regulate their own O2. Easy peasy."

117. That same day, Mobile Care's information technology officer made the change, thereby changing the patient's medical record to falsely state the patient was unable to regulate her own oxygen.

118. Having falsely altered its records, on May 12, 2015, Mobile Care submitted or caused the submission of a false claim for $599.18 for this ambulance transportation to the Medicare program. On May 28, 2015, Medicare's Ohio contractor CGS Administrators paid Mobile Care $254.26 for Patient 1's medically unnecessary ambulance transport on May 7, 2015.

B. Example 2

119. On December 10, 2013, Mobile Care began transporting Patient 2, a patient with end stage renal disease, from a nursing facility in Ohio where she resides, to a dialysis facility in Ohio.

120. When the Mobile Care EMTs arrived at the nursing facility to pick up Patient 2, she was sitting in her wheelchair, ready for transport to her dialysis facility. When a patient is found ready for transport in a wheelchair, that is a clear indication that the patient is not at risk from falling from her wheelchair, the patient is not bedridden, and transport by stretcher in an ambulance is not medically necessary. The only reason provided as to why transport by ambulance was required is "weakness and obesity" and "risk of falls." But absent information as to why the patient is at risk of falling out of a wheelchair, "risk of falls" simply means that the patient is a fall risk if they walk. Thus, the justification provided by Mobile Care was not sufficient to demonstrate that it was medically necessary to transport Patient 2 by ambulance instead of in her wheelchair by ambulette van.

121. Nevertheless, Mobile Care transported Patient 2 to and from her dialysis facility on December 10, 2013 in an ambulance.

122. After this initial transport, Mobile Care knew that no medically necessary reason justified billing Medicare for Patient 2 to be transported by ambulance. Nevertheless, Mobile Care continued to transport Patient 2 by ambulance to and from her dialysis facility on December 12, 2013, December 14, 2013, and December 17, 2013.

123. The December 10, 2013 and December 14, 2013 transports of Patient 2 were listed on a spreadsheet maintained by Mobile Care Billers that listed ambulance transports for which no medical necessity existed to bill Government healthcare programs for ambulance transportation. This spreadsheet was given to Mobile Care management. Nevertheless, these ambulance transports were billed to the Medicare Part B program anyway.

124. In addition, Medicare Part B requires a written order from the patient's attending physician or other caregiver certifying that the medical necessity requirements are met. 42 C.F.R.

§ 410.40(d)(2)(i). For repetitive nonemergency ambulance transportation, the certification must be dated no earlier than 60 days prior to the transport. *Id*. If the transportation is "unscheduled," the certification can be obtained within 48 hours after the transportation.

125. No timely ambulance certification existed for Patient 2 for her December 2013 ambulance transportation. In fact, on December 12, 2013, a Certified Nurse Practitioner provided an ambulette certification for Patient 2.

126. Mobile Care submitted or caused the submission of a false claim for payment of $507.53 to the Medicare Part B program for each one of these eight transports of Patient 2 by ambulance. Through Medicare Part B Contractor CGS Administrators, Mobile Care was paid $177.17 for each of these eight ambulance transports of Patient 2, for a total of $1,417.36.

C. Example 3

127. Between April 14, 2014 and July 23, 2015, Patient 3 has been transported by Mobile Care 164 times from her nursing facility in Ohio in her wheelchair by ambulette van.

128. As Patient 3 has end stage renal disease, she needs to be transported to a dialysis facility in Ohio several days a week.

129. Even though Patient 3 is typically able to travel in her wheelchair in an ambulette van, on approximately October 17, 2014, her nursing home asked that Patient 3 be transported by ambulance to dialysis, not because Patient 3 required transport by ambulance, but because the dialysis facility did not want to move Patient 3 from her wheelchair into a dialysis chair, even though the dialysis facility has special equipment to mechanically move patients in Patient 3's physical condition.

130. On October 17, 2014, when the ambulance crew arrived to pick up Patient 3 to take her to dialysis, they found her sitting in her wheelchair. They transferred her onto a

stretcher. She sat up on the stretcher for comfort rather than lying down on it. Patient 3 was transported to and from her dialysis treatment on October 17, 2014 by ambulance.

131. Relator White contacted CMS in November 2014, to ask whether the medical necessity for Medicare to pay for ambulance transportation is present when dialysis treatment centers and doctors' offices require that patients be transported by ambulance so that they would not need to lift patients. CMS informed Relator White that such patients would not meet Medicare's medical necessity requirements. Relator White advised Eric McAllister of CMS's response to her email question on this issue.

132. With full knowledge that Patient 3 did not require ambulance transport, on dozens of occasions from February 2015 to the present, Mobile Care nevertheless transported Patient 3 in an ambulance and billed both Medicare Part B and the MyCare Ohio program for this transport.

133. Mobile Care submitted or caused the submission of false claims for $620.63 to the Medicare Part B program for each of two ambulance transports of Patient 3 on October 17, 2014. Medicare Part B Contractor CGS Administrators then paid Mobile Care for each of these two ambulance transports.

D. Example 4

134. Patient 4 is a middle-aged patient with multiple sclerosis. He frequently travels from the nursing facility where he resides in his wheelchair via ambulette van. For example, on both December 2, 2013 and January 9, 2014, Mobile Care transported Patient 4 from his nursing facility in Ohio to and from doctor appointments in an ambulette van.

135. On December 18, 2013, Eric McAllister and Matt Miller arrived at Patient 4's nursing facility to transport him. When they arrived, Patient 4 was sitting in his wheelchair.

Nevertheless, Mr. McAllister and Mr. Miller transferred Patient 4 onto a stretcher using a mechanical lift and transported him to a hospital in Ohio for a surgical consultation via ambulance. After the appointment, they transported him back to his nursing facility in their ambulance. Upon his arrival, the patient was lifted back into his wheelchair.

136. Likewise, on December 31, 2013, Mobile Care transported Patient 4 from the hospital back to his nursing facility in an ambulance.

137. Mobile Care's Patient Care Reports for Patient 4 for these ambulance transports on December 18, 2013 and December 31, 2013 show no medically necessary reason that Patient 4 required ambulance transport.

138. The December 31, 2013 transport of Patient 4 was listed on a spreadsheet maintained by Mobile Care's billers that listed ambulance transports for which no medical necessity existed to bill Government healthcare programs for ambulance transportation. This spreadsheet was given to Mobile Care management.

139. Nevertheless, Mobile Care caused the Medicare Part A program to be billed for this treatment by billing Patient 4's facility for this treatment.

140. On February 5, 2014, Medicare's Ohio contractor CGS Administrators paid Mobile Care $181.28 for Patient 4's medically unnecessary ambulance transport on December 31, 2013.

E. Example 5

141. Patient 5 wears a walking boot due to a fractured right ankle. She also has a wound in her right knee where her knee had to be drained following a knee replacement surgery.

142. On June 4, 2015, June 15, 2015, and June 29, 2015, Mobile Care transported Patient 5 from the nursing facility where she resides in Ohio to doctor appointments in Ohio and then back to her facility.

143. A Mobile Care Patient Care Report dated June 4, 2015 indicates that Patient 5 is non-weight bearing on her right leg until after her fracture heals. The same Patient Care Report states that as long as Patient 5 does not move her ankle, her pain is a 1-2, which is a minimal level.

144. However, as a Mobile Care Patient Care Report for June 15, 2015 indicates, nothing prevents Patient 5 from putting weight on her left foot. On June 15, 2015, the Mobile Care EMTs arrived at Patient 5's facility to find her sitting up. Patient 5 stood up and pivoted on her left leg as she was transferred onto the stretcher.

145. Likewise, on June 29, 2015, Patient 5 stood up and pivoted on her left foot as she was transferred onto the stretcher. She denied any pain, except "on movement or palpation."

146. Given her ability to stand on her non-fractured foot, and the fact that her pain level is not great enough to justify ambulance transport, for all six of her transports there was no medically necessary reason for Patient 5 to be transported by ambulance instead of in a wheelchair by ambulette van.

147. Nevertheless, on each occasion, Mobile Care transported Patient 5 by ambulance and billed the MyCare Ohio program for these medically unnecessary ambulance transports.

148. Mobile Care again transported Patient 5 by ambulance on August 5, 2015 and then submitted a paper claim on CMS Form 1500 for payment of $508.50 from the MyCare Ohio program, even though Relator Cunningham alerted Eric McAllister that Patient 5's wheelchair was in the room when the ambulance arrived to take her to her doctor appointment.

149. Mobile Care also submitted false claims for payment by the MyCare Ohio program for ambulance transport of Patient 5 on June 4, 2015 (two claims for $508.50 each); on June 15, 2015 (two claims for $508.50 each); and on June 29, 2015 (two claims for $498.75 each).

COUNT ONE
False Claims Act: Presentation of False Claims in Violation of 31 U.S.C. § 3729(a)(1)(A)

150. The United States realleges and incorporates by reference paragraphs 1 through 149 as though fully set forth herein.

151. By submitting claims to Medicare for payment for services not performed or provided in accordance with Medicare requirements, the Defendant knowingly presented false or fraudulent claims for payment, or knowingly caused false or fraudulent claims for payment to be presented, to the United States, in violation of 31 U.S.C. § 3729(a)(1).

152. By virtue of the false or fraudulent claims made or caused to be made by the Defendant, the United States suffered damages and therefore is entitled to statutory damages under the False Claims Act, to be determined at trial, plus a civil penalty for each violation.

COUNT TWO
False Claims Act: Making or Using False Record or Statement in Violation of 31 U.S.C. § 3729(a)(1)(B)

153. The United States realleges and incorporates by reference paragraphs 1 through 152 as though fully set forth herein.

154. The Defendant knowingly made, used, or caused to be made or used, false records or false statements material to getting false or fraudulent claims paid or approved by the United States.

155. By virtue of the false or fraudulent claims made or caused to be made by the Defendant, the United States suffered damages and therefore is entitled to statutory damages under the False Claims Act, to be determined at trial, plus a civil penalty for each violation.

COUNT THREE
Unjust Enrichment

156. The United States realleges and incorporates by reference paragraphs 1 through 155 as though fully set forth herein.

157. This is a common law claim for unjust enrichment. This Court has jurisdiction pursuant to 28 U.S.C. § 1345.

158. By submitting claims for payment for services that were not provided or were not medically necessary, the Defendant received certain Government funds to which it was not entitled.

159. As a result of the acts set forth in this count, the Defendant was unjustly enriched at the expense of the United States, under circumstances dictating that, in equity and good conscience, the money should be returned to the United States.

COUNT FOUR
(Payment By Mistake)

160. The Plaintiff realleges and incorporates by reference paragraphs 1 through 159 as though fully set forth herein.

161. This is a common law claim for payment by mistake. This Court has jurisdiction pursuant to 28 U.S.C. § 1345.

162. By submitting claims for payment for services that were not provided or were not medically necessary, the Defendant caused the United States to pay the Defendant certain Government funds to which it was not entitled.

163. At the time the United States made such payments, the United States was unaware of the Defendant's conduct described in this Complaint. The United States' erroneous belief was material to making the payments at issue. Had the United States known of the conduct at issue, it would not have made the payments it did.

164. As a result of the acts set forth in this Count, the United States has been damaged in an amount to be determined at trial, and is entitled to recover these monies that were paid to the Defendant by mistake.

PRAYER FOR RELIEF

WHEREFORE, the United States requests that the Court enter judgment in its favor and against the Defendant as follows:

On the First and Second Causes of Action under the False Claims Act, for the amount of statutory damages, such civil penalties, fees and costs, as provided by law.

On the Third and Fourth Causes of Action, for unjust enrichment and payment by mistake, for the damages sustained and/or amounts by which the Defendant was unjustly enriched or by which the Defendant retained illegally obtained monies, plus interest, costs and expenses.

DEMAND FOR JURY TRIAL

The United States of America hereby demands a trial by jury.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 20th day of March, a true and correct copy of the foregoing document was filed with the Court using the Court's CM/ECF system and was served upon each attorney of record via ECF notification.

s/*Margaret A. Castro*
MARGARET A. CASTRO