CV18-5214

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[UNDER SEAL]

WEINSTEIN, J.

GOLD, M.J.

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

[UNDER SEAL],

Plaintiffs,

- against -

[UNDER SEAL],

Defendants.

No. _____

COMPLAINT

FILED IN CAMERA AND UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)

JURY TRIAL DEMANDED

DOCUMENT TO BE KEPT UNDER SEAL

DO NOT ENTER INTO PACER

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** Motion for admission Pro Hac Vice to be filed*

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UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA, the States of NEW JERSEY and NEW YORK and the City of NEW YORK CITY *ex rel*. ANU DODDAPANENI and CHRISTIAN REYES, Plaintiffs, - against - AMIT POONIA, M.D.; NEW JERSEY INTERVENTIONAL PAIN MANAGEMENT CENTER, P.C.; NY INTERVENTIONAL PAIN MANAGEMENT P.C.; ADVANCED INTERVENTIONAL PAIN MANAGEMENT CENTER, LLC; INTERVENTIONAL PAIN MANAGEMENT & ORTHO SPINE CENTER,	No. _____ **COMPLAINT** **FILED IN CAMERA AND UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)** **JURY TRIAL DEMANDED**

LLC; INTERVENTIONAL PAIN MANAGEMENT CENTER PC; ADVANCED MULTISPECIALTY GROUP; CENTRAL JERSEY PAIN INSTITUTE LLC; GLOBAL ANESTHESIA GROUP LLC; PARK AVENUE SURGERY CENTER LLC; SPRINGFIELD SURGERY CENTER LLC; ENDO SURGI CENTER OF OLD BRIDGE LLC; MAIN AVENUE CLIFTON SURGERY CENTER LLC; PREMIUM INTERVENTIONAL PAIN MANAGEMENT; SYNERGY MEDICAL LABORATORIES, INC.; UNIVERSAL TRANSPORTATION SERVICE LLC,

Defendants.

Qui Tam Plaintiffs and Relators Anu Doddapaneni and Christian Reyes ("Relators"), through their attorneys Phillips & Cohen LLP, and on behalf of the United States of America ("United States" or the "Government) and the Plaintiff-States of New Jersey and New York for their complaint against Defendants Amit Poonia, M.D., New Jersey Interventional Pain Management Center P.C., New York Interventional Pain Management P.C., Advanced Interventional Pain Management Center LLC, Interventional Pain Management & Ortho Spine Center LLC, Interventional Pain Management Center P.C., Advanced Multispecialty Group, Central Jersey Pain Institute LLC, Global Anesthesia Group LLC, Park Avenue Surgery Center LLC, Springfield Surgery Center LLC, Endo Surgi Center of Old Bridge LLC, Main Avenue Clifton Surgery Center LLC, Premium Interventional Pain Management, Synergy Medical Laboratories Inc., and Universal Transportation Service LLC (collectively, "Defendants") allege, based upon personal knowledge, relevant documents, and information and belief, as follows:

I. INTRODUCTION

1. This is an action to recover damages and civil penalties on behalf of the United States of America and the States of New Jersey and New York arising from false and/or fraudulent claims caused to be made by Defendants and/or its agents, employees, and co-conspirators in violation of the federal False Claims Act, 31 U.S.C. §§ 3729 *et seq.* ("the Act" or "FCA"); the federal Anti-Kickback Statute ("AKS"), 42 U.S.C. § 1320a-7b(b), the federal Stark Law, 42 U.S.C. § 1395nn; and the state false claims statutes of New Jersey, N.J. Stat. §§ 2A:32C-3(a)–(b), (g); and New York, N.Y. State Fin. §§ 189(1)(a)-(b), (g), (h).

2. The federal False Claims Act was originally enacted during the Civil War. In 1986, after finding that fraud in federal programs was pervasive and that the FCA was in need of modernization, Congress substantially amended the FCA to enhance the ability of the United States Government to recover losses sustained due to fraud against it. The

FCA allows any person with information about an FCA violation to bring an action on behalf of the United States and to share in any recovery. The FCA requires the Complaint to be filed under seal for a minimum of 60 days (without service on the defendant during that time) to allow the government time to conduct its own investigation and to determine whether to join the suit.

3. Defendants began their scheme in or around 2011 and continue to engage in it at the time of filing this Complaint. Defendants knowingly submit false or fraudulent claims including claims for medically unnecessary diagnostic services and interventional procedures that pose an unreasonable and unnecessary risk of patient harm. Defendants have received millions of dollars each year in wrongful reimbursement from Medicare, Medicaid, and other government payors.

4. Defendants' conduct violates the federal FCA and analogous state and local statutes. The federal FCA prohibits, among other things, knowingly presenting or causing the presentation of a false or fraudulent claim, and/or knowingly making or causing to be made, a false record or statement material to a false or fraudulent claim for payment or approval to the federal government or to a grantee of the federal government. 31 U.S.C. §§ 3729(a)(1)(A), (B). It also prohibits knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the government. *Id.* § 3729(a)(1)(G). Any person who violates the FCA is liable for a civil penalty for each violation, plus three times the amount of the damages the United States sustains. *Id.* § 3729(a)(1). State and local statutes proscribe similar conduct and provide for similar remedies.

5. Accordingly, *Qui Tam* Plaintiffs-Relators seek to recover all available damages, civil penalties, and other relief for the continuing violations alleged in this Complaint in every jurisdiction to which Defendants' misconduct has extended.

II. THE PARTIES

6. Dr. Amit Poonia owns all Defendant entities. Dr. Poonia is a physician who specializes in interventional pain management. Dr. Poonia founded Interventional Pain Management Center P.C. in or around 2011, and subsequently founded numerous related entities and locations. Dr. Poonia also acts as the medical director for some of the Defendant entities. Collectively, all Defendant entities will be referred to as "IPMC."

7. IPMC has twelve locations in New York and New Jersey. Four locations are surgery centers, and the other eight are office locations.

8. The surgery centers are located at:

- 105 Morris Avenue, Springfield Township (Union County), New Jersey
- 42 Throckmorton Lane, Old Bridge, New Jersey
- 3848 Park Avenue, Edison, New Jersey
- 1048 Main Avenue, Clifton, New Jersey

9. The medical offices are located at:

- 406 15th Street, Brooklyn, New York
- 2537 Amboy Road, Staten Island, New York
- 3 Cornwall Drive, East Brunswick, New Jersey
- 452 Lakehurst Road, Toms River, New Jersey
- 2045 State Route 35, South Amboy, New Jersey
- 321 60th Street, West New York, New Jersey
- 1868 Hooper Avenue, Toms River, New Jersey
- 763 Convery Boulevard, Perth Amboy, New Jersey

10. In order to evade scrutiny from insurance audits, Dr. Poonia has created many corporate entities for billing purposes. IPMC staff are instructed to bill using certain corporate entities, depending on the patient's insurance and the service rendered. The various corporate entities are not typically associated with any particular office or

surgery center, thus different entities bill for services performed at the same location. These corporate entities include:

11. New Jersey Interventional Pain Management Center, P.C., which has a mailing address listed as 3 Cornwall Drive in East Brunswick, New Jersey. Dr. Poonia is listed as the medical director. The entity's NPI number is 1295163343.

12. New York Interventional Pain Management P.C., which has a mailing address listed at 3848 Park Avenue, Suite 101 in Edison, New Jersey. Dr. Poonia is the medical director. The entity's NPI number is 1649691791.

13. Advanced Interventional Pain Management Center, LLC, which has a mailing address listed at 3848 Park Avenue, Suite 101 in Edison, New Jersey. The entity's NPI number is 1205227030.

14. Interventional Pain Management & Ortho Spine Center, LLC, which has a mailing address at listed at 3848 Park Avenue, Suite 101 in Edison, New Jersey. Dr. Sharma, Dr. Poonia's wife, is listed as the organization's medical director. The entity's NPI number is 1225494016.

15. Interventional Pain Management Center P.C., which has an address listed at 668 5th Avenue, in Brooklyn, New York. The entity's NPI number is 1710308887.

16. Advanced Multispecialty Group, which has a mailing address listed at 3848 Park Avenue, Suite 101, in Edison New Jersey. Dr. Poonia is listed as the Medical Director. The entity's NPI number is 1326475211.

17. Central Jersey Pain Institute LLC, which has an address listed at 3 Cornwall Drive Suite A, in East Brunswick, New Jersey. The entity's NPI number is 1386924538.

18. Global Anesthesia Group LLC, which has a mailing address listed at 3848 Park Avenue Suite 101, in Edison, New Jersey. Dr. Poonia is listed as the medical director. The entity's NPI number is 1023377025.

19. Park Avenue Surgery Center LLC, which has a mailing address listed at 3848 Park Avenue Suite 101, in Edison, New Jersey. The entity's NPI number is 1881997930.

20. Springfield Surgery Center, LLC, which has a mailing address listed at 105 Morris Avenue, 1st Floor, in Springfield, New Jersey. Dr. Poonia is listed as the organization's President. The entity's NPI number is 1518300102.

21. Endo Surgi Center of Old Bridge LLC's office, which has a mailing address listed at 3848 Park Avenue Suite 101, in Edison, New Jersey. The entity's NPI number is 1801987805.

22. Main Avenue Clifton Surgery Center LLC, which has a mailing address listed at 3848 Park Avenue Suite 101, in Edison, New Jersey. Its physical office is located at 1084 Main Avenue in Clifton, New Jersey. The entity's NPI number is 1134513260.

23. Premium Interventional Pain Management, which has a mailing address listed at 3848 Park Avenue Suite 101, in Edison, New Jersey. Its physical office is located at 2105 Jackson Street, First Floor, in Houston, Texas. Dr. Sharma is listed as the organization's medical director. The entity's NPI number is 1568816031.

24. Dr. Poonia also owns a toxicology laboratory, Synergy Medical Laboratories, Inc. Synergy's address is 42 Throckmorton Lane, Suite 1 in Old Bridge, New Jersey.

25. Dr. Poonia also owns a medical transportation service, Universal Transportation Service LLC, incorporated in New Jersey.

26. Collectively, these entities will be referred to as "IPMC" or "Defendants".

27. *Qui Tam* Plaintiff and Relator Anu Doddapaneni lives in New York City. Relator worked for Defendants as an Administrator from December 2013 through April 2018 at the Brooklyn, New York office. Relator hired, trained, and supervised staff members, oversaw billing and claims submission, managed the EMR system, and

performed other administrative functions for Defendants. Relator Doddapaneni witnessed Defendants' fraudulent practices directly.

28. *Qui Tam* Plaintiff and Relator Christian Reyes lives in New Jersey. Relator worked for Defendants as a Practice Administrator and Medical Assistant in the Brooklyn and Staten Island offices from December 2013 until April 2018. As a Practice Administrator, Relator Reyes supervised, trained, and hired staff for pain management and physical therapy services, managed billing, payroll, accounts and invoices, clinical providers schedules, the EMR system, and more. As a Medical Assistant he took patient histories, ordered testing, discussed patients' treatment with them, and carried out directions on treatment from physicians. Relator Reyes also worked for Universal Transportation Services as a driver. Relator Reyes witnessed Defendants' fraudulent practices directly.

III. JURISDICTION AND VENUE

29. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331, 28 U.S.C. § 1367, and 31 U.S.C. § 3732, the last of which confers jurisdiction on this Court for actions brought pursuant to 31 U.S.C. §§ 3729 and 3730.

30. This Court has personal jurisdiction over Defendants pursuant to 31 U.S.C. § 3732(a), which authorizes nationwide service of process, and because Defendants have minimum contacts with the United States. Moreover, Defendants can be found in, reside, and/or transact or have transacted business in this District.

31. Venue is proper in this District pursuant to 28 U.S.C. §§ 1391(b) and 1395(a), and 31 U.S.C. § 3732(a) because Defendants can be found in and/or transact or have transacted business in this District. At all times relevant to this Complaint, Defendants regularly conducted substantial business, maintained employees, and/or made significant sales in this District. In addition, statutory violations, as alleged in this Complaint, occurred in this District.

IV. APPLICABLE LAW

A. The False Claims Act

32. The federal False Claims Act (the "FCA") was originally enacted during the Civil War. After finding that fraud in federal programs was pervasive and that the FCA, which Congress characterized as the primary tool for combating government fraud, was in need of modernization, Congress substantially amended the FCA in 1986 to enhance the ability of the United States Government to recover losses sustained as a result of fraud against it. Congress intended that the 1986 amendments would create incentives for individuals with knowledge of fraud against the Government to disclose the information without fear of reprisals or Government inaction, and to encourage the private bar to commit legal resources to prosecuting fraud on the Government's behalf. Congress further substantially amended the FCA in 2009 and 2010 to, among other things, strengthen whistleblowers' ability to bring and maintain actions on the Government's behalf.

33. The FCA prohibits, *inter alia*: (a) knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval; and (b) knowingly making or using, or causing to be made or used, a false or fraudulent record or statement material to a false or fraudulent claim; and (c) knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the government. 31 U.S.C. §§ 3729(a)(1)(A), (B), (G). Any person who violates the FCA is liable for a civil penalty of up to $21,563 for each violation, plus three times the amount of the damages sustained by the United States. 31 U.S.C. § 3729(a)(1).

34. For purposes of the FCA, a person "knows" a claim is false if that person: "(i) has actual knowledge of [the falsity of] the information; (ii) acts in deliberate

ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information." 31 U.S.C. § 3729(b)(1). The FCA does not require proof that the Defendant specifically intended to commit fraud. *Id.* Unless otherwise indicated, whenever the word "know" and similar words indicating knowledge are used in this Complaint, they mean knowledge as defined in the FCA.

35. The FCA allows any person having information about an FCA violation to bring an action on behalf of the United States, and to share in any recovery. Such a person is known as a qui tam "relator." The FCA requires that the qui tam relator's complaint be filed under seal for a minimum of 60 days (without service on the defendant during that time) to allow the government time to conduct its own investigation and to determine whether to join the suit.

B. The Anti-Kickback Statute

36. The federal health care Anti-Kickback Statute, 42 U.S.C. § 1320a-7b ("AKS"), arose out of Congressional concern that financial inducements can influence health care decisions and result in goods and services being more expensive, medically unnecessary, and harmful to patients.

37. To protect the integrity of federal health care programs, Congress prohibited the payment of kickbacks in any form, regardless of whether the kickback actually gives rise to overutilization or unnecessary care. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, §§ 242(b) and (c); 42 U.S.C. § 1320a-7b, Medicare and Medicaid Antifraud and Abuse Amendments, Pub. L. No. 95-142; Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93.

38. The AKS prohibits any person or entity from making or accepting payments to induce or reward any person for referring, recommending or arranging for the purchase of any item for which payment may be made under a federally funded health care program. 42 U.S.C. § 1320a-7b(b). The AKS has been interpreted to cover any

arrangement where *one* purpose of the remuneration was to obtain money for the referral of services or to induce further referrals.

39. The AKS also prohibits employers from paying their employees bonuses based directly or indirectly on the volume or value of referrals. 42 C.F.R. § 411.357(c)(ii).

40. Compliance with the AKS is a precondition to both participation as a health care provider in and payment under Medicaid, Medicare, CHAMPUS/TRICARE, CHAMPVA, Federal Employee Health Benefit Program, and other federal health care programs. 42 U.S.C. § 1320a-7(b)(7).

41. For example, to establish eligibility and seek reimbursement from the

42. Medicare Program, hospitals and other providers enter into Provider Agreements with CMS. As part of that agreement, the provider must sign the following certification:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to [me]. The Medicare laws, regulations and program instructions are available through the [Medicare] contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the [provider's] compliance with all applicable conditions of participation in Medicare.

43. Similarly, compliance with the federal AKS is a prerequisite to a provider's right to receive or retain reimbursement payments from government-funded healthcare programs.

44. In sum, providers who participate in federal health care programs must certify (often explicitly, in a provider agreement or on claim forms) that they have complied with the applicable federal rules and regulations, including the AKS.

45. Any party convicted under the AKS must be excluded from federal health care programs (*i.e.*, not allowed to bill for services rendered) for a term of at least five years. 42 U.S.C. § 1320a-7(a)(1).

46. Even without a conviction, if the Secretary of the Department of Health and Human Services ("HHS") finds administratively that a provider has violated the statute, the Secretary may exclude that provider from the federal health care programs for a discretionary period (in which event the Secretary must direct the relevant State agency to exclude that provider from the State health program), and may consider imposing administrative sanctions of $50,000 per kickback violation. 42 U.S.C. § 1320a-7(b).

47. Pursuant to the Affordable Care Act passed in 2010, any claim submitted to a federal health care program that includes items or services resulting from violations of the AKS constitutes a false or fraudulent claim for purposes of the False Claims Act. 42 U.S.C. § 1320a-7b(g).

C. The Stark Law

48. Congress passed the federal Stark Law, also known as the Physician Self-Referral Law, as part of the Omnibus Budget Reconciliation Act of 1990. 42 U.S.C. § 1395nn. The Stark Law prohibits physician self-referrals to entities furnishing designated health services ("DHS") if that physician has a financial arrangement with the entity. Congress passed the law due to concern for the conflict of interest posed by physicians referring patients to entities where the physician would financially benefit as a result of the referral. Congress feared that allowing physicians to refer patients based on financial gain could lead to overutilization of DHS based on physician self-interest rather than medical need.

49. Under the Stark Law, a "physician who has a direct or indirect financial relationship with an entity . . . may not make a referral to that entity for the furnishing of DHS for which payment otherwise may be made under Medicare." 42 C.F.R. § 411.353(a); 42 U.S.C. § 1395nn(a)(1)(A).

50. The Stark Law regulations define a "financial relationship" as "a direct or indirect compensation arrangement . . . with an entity that furnishes DHS." 42 C.F.R. § 411.354(a)(1)(ii).

51. A compensation arrangement is "any arrangement involving remuneration, direct or indirect, between a physician (or a member of a physician's immediate family) and an entity." 42 C.F.R. § 11.354(c).

52. While the Stark Law regulations do contain an exception for "bona fide employment relationships" between a physician and the employing entity, compensation under this arrangement must be "consistent with fair market value for services performed" and "not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician." 42 C.F.R. § 411.357(c)(2)(i)-(ii).

53. If an entity furnishes DHS due to a prohibited referral, that entity may not present, or cause to be presented, that claim for DHS to Medicare or to any individual, third party payer, or any other entity. 442 U.S.C. § 1395nn (a)(1)(B); 42 C.F.R. § 411.353(b). No Medicare payment may be made for a DHS furnished pursuant to a prohibited referral. 42 C.F.R. § 411.353(c)(1). Furthermore, an entity that received payment for prohibited DHS must refund all collected amounts from prohibited referrals on a timely basis. 42 U.S.C. §1395nn(g)(2); 42 C.F.R. § 411.353(d). The OIG may impose a penalty against any person who fails to refund these amounts on a timely basis. 42 C.F.R. § 1003.102(b)(9).

54. The Stark Law also sets out monetary penalties. "Any person that presents or causes to be presented a bill or a claim for a service that such person knows or should know is for a service for which payment may not be made under [the Stark Law] . . . shall be subject to a civil money penalty of not more than $15,000 for each such service." 42 U.S.C. § 1395nn(g)(3); 42 C.F.R. § 1003.102(a)(5).

55. Violations of the Stark Law can form the basis for violations of the False Claims Act. *See e.g., U.S. ex rel. Baklid-Kunz v. Halifax Hosp. Med. Ctr.*, No. 6:09-cv-1002-Orl-31DAB, 2012 U.S. Dist. LEXIS 36304, at *8 (M.D. Fla. Mar. 19, 2012), citing *U.S. ex rel. Schmidt v. Zimmer, Inc*., 386 F.3d 235, 243 (3d Cir. 2004) ("Falsely certifying compliance with the Stark or Anti-Kickback Acts in connection with a claim submitted to a federally funded insurance program is actionable under the FCA.").

V. FEDERAL, STATE, AND CITY HEALTH CARE PROGRAMS

A. Medicare

56. Medicare is a federally funded health-insurance program primarily benefitting the elderly. Congress established the Medicare program, or Title XVIII of the Social Security Act, in 1965 with the goal of providing nationalized health coverage for Americans aged 65 or older. In addition to the elderly, a large portion of Medicare's patient population is disabled. In 2015, Medicare covered roughly 55 million Americans, either through the traditionally federally administered Medicare program or through a private health plan, also known as a Medicare Advantage plan. Medicare is funded through the Medicare Trust Fund, which relies on workers' payroll deductions and government funds.

57. The United States Department of Health and Human Services ("HHS") and the Centers for Medicare and Medicaid Services ("CMS"), an agency within HHS, direct and manage the Medicare program.

58. Medicare has four parts: Part A, providing hospital insurance; Part B, providing medical insurance, Part C, which includes managed care plans; and Part D, which provides prescription drug benefits.

59. Section 1862 of the Social Security Act, codified at 41 U.S.C. §1395y(a)(1)(A), explains that under Medicare, "no payment may be made under part A or part B for any expenses incurred for items or services . . . [that] are not reasonable and necessary for the prevention of illness." Medicare reimburses only for the cost of

services that are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." 42 U.S.C. § 1395y(a)(1)(A).

60. CMS will deny a claim where the service or drug provided is not reasonable and necessary and the necessity is not documented in the medical record. 42 C.F.R. § 410.32(d)(2)(i)-(iii); (d)(3)(ii)-(iii).

61. Medicare regulations require providers and suppliers to certify that they meet, and will continue to meet, the requirements of the Medicare statute and regulations. 42 C.F.R. § 424.516(a)(1).

B. Medicaid

62. Medicaid is a public-assistance program created in 1965 that provides payment of medical expenses for low-income and disabled patients. Funding for Medicaid is shared between the federal government and those states participating in the program. Medicaid is the largest source of funding for medical services for America's poor and disabled. Each provider that participates in the Medicaid program must sign a provider agreement with his or her state.

63. Federal regulations require each state to designate a single state agency responsible for the Medicaid program. The agency must create and implement a "plan for medical assistance" that is consistent with Title XIX of the Social Security Act and with the regulations the Secretary of HHS promulgates. Although Medicaid is administered on a state-by-state basis, the state programs adhere to federal guidelines. Federal statutes and regulations restrict the items and services for which the federal government will pay through its funding of state Medicaid programs.

64. Like Medicare, Medicaid covers medical services only if they are necessary to diagnose or treat a patient's particular medical condition. Medicaid routinely pays for testing and services if they meet those standards. Although Medicaid

reimbursement varies depending on the state in which the billing is done, all services provided must meet the medical necessity threshold.

65. Physicians receiving reimbursement from Medicaid must make express and/or implied certifications in their state Medicaid provider enrollment forms that they will comply with all federal and state laws applicable to Medicaid.

C. Other State and Local Government Funded Health Care Programs

66. The New York State Insurance Fund ("NYSIF") is a New York state government-run insurance carrier established as part of the Workers' Compensation Act of 1914, N.Y. Worker's Compensation Law §§ 76-100. It provides workers' compensation benefits for employers in New York to insure their employees and is the largest workers' compensation carrier in New York. All businesses in New York can purchase insurance through the NYSIF if they choose. The NYSIF is a self-supported insurance carrier that sustains itself by collecting premiums from employers in order to pay out claims to injured employees.

67. New Jersey's Uninsured Employer's Fund (UEF) is a fund established as part of the New Jersey Workers' Compensation Law, which temporarily provides benefits to injured workers employed by businesses without workers' compensation insurance. N.J. Stat. Ann. §§ 34:15-120.1-120.14.

68. New Jersey also has a workers' compensation Second Injury Fund, which provides medical benefits to partially disabled workers who then experience another work-related injury that renders them completely disabled. The Second Injury Fund provides benefits covering medical expenses related to the employee's second incurred injury. N.J. Stat. Ann. § 34:15-95.

69. New York City provides health insurance for most city employees through the New York City Law Department Workers' Compensation Division, which administers the City's self-insured workers' compensation. The Law Department Workers' Compensation Division administers workers' compensation claims that are

paid out by various agencies to their employees, including: the City of New York, the New York City Health & Hospitals Corporation, the Police Department, the Department of Correction, the Fire Department, the Department of Education of the City of New York, the City University of New York, the New York City Board of Elections, and more.

VI. FACTUAL BACKGROUND

70. Defendants, which consist of Dr. Poonia, the numerous corporate entities that make up IPMC, and a toxicology laboratory and transit service company, fraudulently seek to reap as much money as possible from Government insurance programs and other insurance payors including by submitting false or fraudulent claims for medically unnecessary diagnostic testing and interventional procedures.

71. Dr. Poonia owns and runs IPMC. His wife, Dr. Adity Sharma, practices at IPMC. IPMC also employs a small number of physicians—usually around four at a time—as salaried employees. Dr. Poonia relies on IPMC's practice administrators—including top administrator Keta Patel—to instruct physician employees and physicians' assistants to implement IPMC's standardized protocols. These protocols are intended to increase revenues for Dr. Poonia, even at the expense of patient welfare.

72. IPMC keeps extensive documentation on what insurance plans reimburse certain procedures, and the reimbursement rates. In particular, Defendants targets patients insured by Medicare and state workers' compensation insurances.

73. Dr. Poonia and his practice administrators knowingly submit or cause the submission of claims for diagnostic testing services and interventional procedures they know to be medically unnecessary. Claims for medically unnecessary services and procedures are not reimbursable under Medicare, Medicaid, and other state and local rules for Government insurance programs and constitute false or fraudulent claims under the federal False Claims Act and the New York and New Jersey False Claims Acts.

A. Defendants Perform Medically Unnecessary Diagnostic Testing and Interventional Procedures

74. Defendants use standard protocols that require performing diagnostic services and interventional procedures and prescribing durable medical equipment even when those procedures and equipment are not medically necessary, pose heightened risks, and/or are detrimental to patients. These protocols include unnecessarily ordering excessive urine drug tests that are performed at Defendants' clinical laboratories; coaching patients to consent to general anesthesia at Defendants' surgical centers for procedures even when local anesthesia in an office would be sufficient; requiring patients to undergo unnecessary lumber discograms, a painful and potentially dangerous procedure; and requiring patients to receive the maximum number of steroidal pain injections even when fewer injections would control the patient's pain. Defendants' protocols are designed to increase revenues and profits even at the expense of patient health and safety.

1. Defendants Cause the Submission of Claims for Urine Drug Tests That Are Not Medically Necessary

75. Urine drug tests, or "UDTs," are used to assess whether patients are using illicit drugs or taking prescribed drugs properly. UDTs are often used in pain management practices to manage the risk of addiction by patients prescribed opioid drugs.

76. UDTs have been a subject of abuse by providers who overutilize these tests to generate revenue for their practices. Because it is medically necessary *in some cases* to repeat tests for a patient, unscrupulous providers overutilize the tests and order repeat testing at frequent intervals for all patients, and/or patients on whom repeated testing is not medically necessary for that patient's specific circumstance.

77. Pursuant to 42 C.F.R. § 410.32(a), all diagnostic tests "must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a

consultation or treats a beneficiary for *a specific medical problem* and who *uses the results in the management of the beneficiary's specific medical problem*." 42 C.F.R. § 410.32(a) (emphasis added).

78. The Office of Inspector General, Department of Health and Human Services, has directed that "laboratories should encourage physicians or other authorized individuals to submit diagnosis information for all tests ordered, as documentation of the medical necessity of the service" and that "Medicare generally does not cover routine screening tests." 63 Fed. Reg. 45076, 45079 (Aug. 24, 1998).

79. Unscrupulous providers abuse UDTs by ordering both qualitative and quantitative levels of testing simultaneously, or by conducting quantitative testing even when the results of the qualitative test do not necessitate further testing. These practices result in more—and more expensive—laboratory testing and claims for reimbursement than medically necessary.

80. Qualitative testing, sometimes called screening testing, should normally be the first level of urine drug testing performed in most cases. Qualitative testing assesses whether drugs within a panel of drugs are present in the patient's sample. A qualitative test can screen for whether a drug is present or absent but it cannot detect the level of that drug.

81. Quantitative testing is the second level of testing that may be performed if a result from the qualitative testing necessitates further testing. Quantitative testing confirms the presence or absence of a specific drug and measures the amount of drug present in the sample. Because quantitative testing is more expensive, and cannot be run simultaneously on an entire panel of drugs, but must be run as a separate test for each drug, it is typically reserved for analysis of the quantity of drugs flagged as suspicious results from a qualitative test.

82. Medicare Administrative Contractor ("MAC") National Government Services, which processes Part A and B claims in New York and other states, has issued a

Local Coverage Determination ("LCD") specifying what the MAC considers medically necessary in urine drug testing. CMS, Local Coverage Determination (LCD) Urine Drug Testing (L36037) (Original effective Date for Services performed on or after 12/01/2015).

83. As this LCD explains, performing quantitative (or "definitive") testing to confirm the result of a qualitative test is only reasonable and necessary "to confirm a presumptive UDT positive result, upon the order of the clinician . . . when the result is inconsistent with the expected result, a patient's self-report, presentation, medical history, or current prescribed medication plan," when "the clinician suspects use of a substance that is inadequately detected or not detected by a presumptive UDT" or "[t]o rule out an error as the cause of a negative presumptive UDT result." *Id*. Simply performing both steps without waiting to see if quantitative testing is needed cannot be reasonable and necessary.

84. Under non-covered services, National Government Services' LCD states that "[r]outine standing orders for all patients in a physician's practice are not reasonable and necessary." *Id*. Standing orders are defined as a "[t]est request for a specific patient representing repetitive testing to monitor a condition or disease for a limited number of sequential visits; individualized orders for certain patients for pre-determined tests based on historical use, risk and community trend patient profiles; [and] clinician can alter the standing order."

85. Defendants' protocols require repetitive and pre-determined testing for a number of sequential visits, even despite stratification of patients' risk of abuse.

86. In addition, the LCD identifies the reasonable and necessary frequency of drug testing in patients on chronic opioid therapy: Random testing 1 to 2 times in a 12-month period for low risk patients; 1 to 2 times every 6 months for moderate risk patients; and 1 to 3 times every 3 months for high risk patients. *Id*.

87. Defendants' protocol requires more frequent testing than is reasonable and necessary.

88. Defendants' standard protocol is to conduct urine drug testing ("UDT") on all IPMC patients.

89. Under its standard protocol, IPMC does not wait for results from the qualitative test before ordering the more expensive and potentially unnecessary quantitative test. IPMC has both qualitative and quantitative tests run on all samples simultaneously.

90. In 2016 IPMC Practice Administrator Keta Patel emailed IPMC doctors and staff with IPMC's policy on UDT. One of IPMC's physician employees, Dr. Hadi Moten, told Relators the UDT protocol was a "red flag."

91. IPMC's UDT protocol specifies that in addition to a medical history and examination upon initial visit, IPMC's policy requires that all patients undergoing their initial evaluation take a test to determine their opioid abuse risk, using IPMC's "opioid risk tool."

92. IPMC's opioid risk tool questionnaire stratifies patients into low, moderate, or high risk categories. Low risk patients are tested every two months. Moderate risk patients are tested on three consecutive visits, and if the results remain consistently acceptable, patients are downgraded to low risk. If not, the patient is upgraded to high risk. High risk patients are tested for six consecutive visits and if the tests are consistent, downgraded to low risk and tested every two to three months. If the tests remain inconsistent then providers are to "discuss possible options and/or discharge."

93. Defendants' protocol requires, as a matter of policy, more frequent testing than is medically necessary and reasonable, as outlined by the National Government Services LCD.

94. As a medical assistant, Relator Reyes collected UDT samples from patients. Relator Reyes saw that Dr. Poonia and Dr. Sharma let patients who have repeatedly failed UDTs remain as patients of the practice with only a verbal warning as long as those patients schedule interventional procedures, the main source of revenue for IPMC. One of IPMC's physician employees, Dr. Como Biagio, complained to Relators that IMPC doctors would allow patients to continue to receive services even though they had failed the UDT and the evident drug use had not been addressed by the physicians with the patients.

95. In addition, even some patients who have not failed UDTs are also threatened by doctors and intimidated into scheduling procedures. IPMC physicians warn these patients that if they do not schedule procedures, they will withhold the patients' prescriptions and eventually discharge these patients from the practice.

96. Dr. Poonia and Dr. Sharma keep notes of patients who fail UDTs and decline interventional procedures. In at least one incident recorded by a patient, physician Dr. Hadi Moten tried to pressure the patient to agree to a pain injection by threatening to stop prescribing opiates to the patient who had failed a UDT.

97. In addition to overutilizing UDTs and performing medically unnecessary UDTs, Dr. Poonia also self-refers the UDTs to his own toxicology lab for analysis. From approximately 2014 to 2016, IPMC used a number of toxicology laboratories to analyze UDTs. These included Strategic Lab Group, used by IPMC at some point in 2014, and Advanced Clinical Laboratory Solutions. Advanced Clinical Solutions is located at 2277-83 Coney Island Avenue #3B, in Brooklyn, New York.

98. At some point in or around 2016, Dr. Poonia directed IPMC to begin sending UDT samples to Synergy Medical Laboratories—a laboratory which appears to be owned by Dr. Poonia. Gokul Sharma, Synergy's Laboratory Administrator, was also an IPMC Manager. Synergy's address is 42 Throckmorton Lane, Suite 1 in Old Bridge, New Jersey—the same address as one of IPMC's surgery centers. Dr. Poonia is listed as

the business's principal per New Jersey's business standing certificate for the company. IPMC used Synergy Medical Laboratories for a while—thus self-referring business to Dr. Poonia's lab from which he profited—before beginning to send UDT samples elsewhere.

99. A claim is properly denied where the service provided is not reasonable and necessary and the necessity is not documented in the medical record, or if the MAC has made a local coverage determination that the service is not covered. 42 C.F.R. §§ 410.32(d)(2)(i)-(iii); (d)(3)(ii)-(iii).

100. By ordering UDTs for all patients regardless of medical necessity, testing patients more frequently than necessary, running qualitative and quantitative testing simultaneously, and self-referring patients to his own laboratory, Dr. Poonia and IPMC submit or caused the submission of false claims to government payors. Patients receiving urine drug tests include Medicare and Medicaid patients, patients insured by the state-funded workers' compensation funds of New York and New Jersey, and patients insured by the City of New York.

2. Defendants Knowingly Submit or Cause to be Submitted Claims for Surgical Center Procedures and Anesthesia that Are Not Medically Necessary

101. Under its routine protocol, Defendants perform epidural, facet, trigger point, knee and joint, and other injections under twilight anesthesia in IPMC's surgery center, even when those procedures could safely be performed in the IPMC office under local anesthesia. Putting patients under anesthesia in a surgery center results in higher reimbursement for Defendants while posing greater risks to patients than does local anesthesia in an office setting.

102. To justify performing pain management injections in the surgery center under twilight anesthesia, Defendants' top administrators, including Practice Manager Patel, instruct medical assistants and physicians to document falsely in the patients' medical records that the patient suffers from "needle phobia," and therefore have to be under anesthesia in order to receive pain injections. This protocol applies to all patients

receiving injections, whether patients are truly afraid of needles or not. Most patients do not have a "needle phobia" that justifies pain injections being performed in a surgery center under anesthesia.

103. For example, on May 26, 2017, Patel instructed IPMC employees by email that to justify medical necessity for workers' compensation patients, their medical record must include a note that "Patient has a needle phobia and anxiety associated with interventional pain procedures. Patient is unable to lie still intraoperative which can lead to severe complications. MAC [monitored anesthesia care] is medically necessary to perform the interventional injection efficiently and to prevent any associated complications."

104. IPMC documents "needle phobia" falsely in patients' medical records to cause insurers, including federal, state, and city-funded insurers, to approve twilight anesthesia and the higher costs associated with performing injections in a surgical center rather than in office.

105. By altering medical records to falsely justify unnecessary anesthesia, and performing medically unnecessary anesthesia on patients, Dr. Poonia and IPMC submit or cause the submission of false claims to government payors. IPMC's patients receiving pain injections under anesthesia in its surgery centers include Medicare and Medicaid patients, patients insured by the state-funded workers' compensation funds of New York and New Jersey, and patients insured by the City of New York.

3. Defendants Knowingly Submit, or Cause to be Submitted, Claims for Lumbar Discograms that Are Not Medically Necessary

106. IPMC's treatment protocol, directed by Dr. Poonia, also requires physicians to perform lumbar discograms for all patients scheduled for spinal surgery.

107. Lumbar discograms are an invasive procedure used to evaluate the source of patients' back pain. These procedures are controversial and often do not yield useful data. Discograms are performed by injecting a dye into the patient's spinal disc, which

can cause pain for the patient. MRIs, CT scans, or Electromyography can also be used to locate the source of patients' back pain and are less invasive and painful.

108. New York's workers' compensation Medical Treatment Guidelines, which prescribe the mandatory standard of care for all workers' compensation cases in New York, do not allow for lumbar discograms absent an exception. The New York State Workers' Compensation Board's Guidelines state that:

> Discography, whether performed as a solitary test or when paired with imaging (e.g., MRI), is not recommended for acute, subacute, chronic back pain or radicular pain syndromes. Improvement in surgical outcomes has not been shown to follow the use of discography, and there is evidence that performing discography on normal discs is associated with an enhanced risk of degenerative changes in those discs in later years.

New York State Workers' Compensation Board, New York Mid and Low Back Injury Medical Treatment Guidelines (2013) *available at* http://www.wcb.ny.gov/content/main/hcpp/MedicalTreatmentGuidelines/MidandLowBackInjuryMTG2012.pdf.

109. On March 31, 2016, IPMC Receptionist and Medical Assistant Mariam Hanna emailed IPMC employees to alert them that "All patients that are proceeding with LUMBAR surgery MUST have a discogram FIRST before putting in the request for surgery."

110. IPMC physician Dr. Schiebert objected to the directive to perform lumbar discograms before every patient's surgery. However, medical assistants still attempt to schedule most patients for discograms unless a physician objects, or the patient's insurance denies the procedure.

111. By performing medically unnecessary lumbar discograms on patients, Dr. Poonia and IPMC submit or cause the submission of false or fraudulent claims to government payors. IPMC's patients receiving medically unnecessary lumbar discograms include Medicare and Medicaid patients, patients insured by the state-funded

workers' compensation funds of New York and New Jersey, and patients insured by the City of New York.

4. Defendants Knowingly Submit, or Cause to be Submitted, Claims for "P-Stims" that Are Not Medically Necessary

112. IPMC also submits, or causes the submission of, of false or fraudulent claims for medically unnecessary and unreasonable services for implantation of "P-Stims" (percutaneously placed microchip-controlled pulsed neurotransmitters) for almost all Medicare beneficiary patients and other patients with insurance that pays for the procedure. P-Stims provide the patient with a continuous flow of electrical pulses to specific nerves that can relieve pain.

113. IPMC's standard protocol is to prescribe P-Stims and submit claims for all Medicare beneficiary patients regardless of individual patient need. Claims for P-Stims implantations also are submitted for patients with insurance other than Medicare, including patients with workers' compensation insurance.

114. P-Stims can be billed using CPT code 64999, other procedures of the nervous system, or 64555, neurostimulator procedures on the peripheral nerves.

115. On or around 2014 or 2015, Medicare conducted an audit of IPMC. Around the same time, Dr. Poonia stopped ordering P-Stim procedures, likely out of concern that the audit would reveal the overutilization of P-Stims. Patel instructed Relator Reyes to tell patients that Medicare no longer covered P-Stims, even though Medicare and some other commercial insurances did cover the procedures when medically necessary.

116. By indiscriminately implanting P-Stims in patients regardless of medical necessity, Dr. Poonia and IPMC submitted or caused the submission of false claims to government payors. IPMC's patients who received medically unnecessary P-Stim procedures included Medicare and Medicaid patients, patients insured by the state-funded

workers' compensation funds of New York and New Jersey, and patients insured by the City of New York.

5. Defendants Knowingly Submit, or Cause to be Submitted, Claims for Neuro-Stim Systems that Are Not Medically Necessary

117. Instead of continuing to implant P-Stims after the Medicare audit, Dr. Poonia determined that IPMC providers should switch to implanting Neuro-Stim Systems ("NSS") in Medicare patients.

118. NSS are similar implants to P-Stims. IMPC's new protocol requires that almost all Medicare patients receive this procedure, without regard to the individual patient's need.

119. NSS are billed using HCPCS code 64555, with an average reimbursement of $173 from Medicare. IPMC's Springfield Surgery Center billed Medicare for hundreds of NSS procedures and received over $1.4 million in reimbursement for NSS procedures in 2016, while the Endo Surgi Center of Old Bridge received over $837,000 for NSS procedures from Medicare in 2016.

120. To follow Dr. Poonia's protocol for Medicare patients to receive NSS procedures, IPMC staff steer Medicare beneficiary patients toward NSS procedures. In one instance, Dr. Moten referred a patient for an epidural injection. IPMC had the patient's primary insurance incorrectly listed as a non-Medicare insurance, when the patient actually had Medicare as a primary payor. When IPMC office coordinator Angela Mannuzza-Gorla realized the mistake, she attempted to change the patient's scheduled procedure from an epidural injection to an NSS procedure because of IPMC's protocol for Medicare beneficiary patients to receive NSS.

121. Ultimately, Relator Reyes pointed out that changing the epidural procedure to NSS without consulting with the patient, when the patient had agreed to the epidural, would be a mistake, and the patient ultimately received the epidural as initially planned.

122. By indiscriminately implanting NSS in patients regardless of medical necessity on patients, Dr. Poonia and IPMC submit or cause the submission of false claims to government payors. IPMC's patients who have received medically unnecessary NSS procedures include Medicare and Medicaid patients, patients insured by the state-funded workers' compensation funds of New York and New Jersey, and patients insured by the City of New York.

6. Defendants Knowingly Submit, or Cause to be Submitted, Claims for Corticosteroid Injections that Are Not Medically Necessary

123. Another IPMC protocol directed by Dr. Poonia requires patients with knee pain to receive a series of three to five injections (depending on the type of injection), even if one or two injections has already provided pain relief.

124. In a March 14, 2015 email, IPMC radiologic technologist Daniel Oliveira detailed this protocol for patients presenting with knee pain. The protocol, imposed by Dr. Poonia, requires that when a patient presents with knee pain, they must receive a series of three corticosteroid knee joint injections, followed by viscosupplementation (a procedure of injecting the knee with lubricating fluids), a genicular nerve block, and a platelet rich plasma injection.

125. Relator Reyes was expected to convince patients that they needed to come in for three epidural or facet injections in order to ensure relief from pain. Some patients will obtain pain relief from one injection. Despite this, IPMC's protocol for epidural or facet injections is to attempt to bring patients in for three injections per year whether those injections are necessary or not. This is done to generate insurance reimbursement without regard to whether the patient requires all three injections to alleviate pain.

126. Defendants also regularly schedule radiofrequency ablation procedures ("RFAs") for patients after facet injections regardless of medical necessity, as part of the treatment protocol. These are performed after cervical, thoracic, or lumbar injections.

127. By administering medically unnecessary corticosteroid injections to patients who have already achieved relief from fewer injections, Dr. Poonia and IPMC submit or cause the submission of false claims to government payors. IPMC's patients who have received medically unnecessary injections include Medicare and Medicaid patients, patients insured by the state-funded workers' compensation funds of New York and New Jersey, and patients insured by the City of New York.

7. Defendants Knowingly Submit or Cause to be Submitted Claims for Durable Medical Equipment that Are Not Medically Necessary

128. Another of Defendants' protocols aims at increasing reimbursement by prescribing durable medical equipment ("DME") for all patients with insurance that will reimburse for such equipment, regardless of patient need.

129. Dr. Poonia and Patel instruct physicians' assistants and medical assistants that it is their responsibility to order TENS units and back, neck, shoulder, knee, elbow, and wrist braces for as many patients as possible.

130. Defendants maintain a list of all patients who receive DME during the year. Medical assistants review this list to determine what DME items have not been ordered for patients with upcoming office visits.

131. IPMC Administrator Lily Shamim instructs providers to note when patients actively refuse DMEs "so when Dr. Poonia questions us to find out the status we can go to the grid+hub notes"—to explain to Dr. Poonia why his protocol of prescribing DMEs to all is not being followed. Patel threatens medical assistants with warnings if they did not carry out this protocol.

132. IPMC physician Dr. Moten told Relators that Shamim's email would be a "red flag" for insurance companies, and that following those procedures could put Dr. Poonia and IPMC at legal risk.

133. Patients who told one medical assistant, Mariam Hanna, that they did not want DMEs were told by her to take the DME and "give it to your friend."

134. By ordering DME for patients regardless of medical necessity, Dr. Poonia and IPMC submit or cause the submission of false claims to government payors. IPMC's patients who have received medically unnecessary DME include Medicare and Medicaid patients, patients insured by the state-funded workers' compensation funds of New York and New Jersey, and patients insured by the City of New York.

B. Defendants Violate the Stark Prohibitions on Self-Referral for Ambulatory Surgery Centers

135. The Stark Law prohibits referrals to an entity where a physician or immediate family member has a financial relationship, whether direct or indirect, with the entity. 42 U.S.C. § 1395nn(a).

136. As the owner of Defendant entities, Dr. Poonia has an "ownership or investment interest" in all Defendant entities, and his wife, Dr. Sharma, has a compensation arrangement with the IPMC entities. 42 U.S.C. § 1395nn(a)(2). Both receive revenue every time a patient receives surgery or other services at IPMC's ambulatory surgery centers or its offices.

137. Dr. Sharma performs consultations on IPMC patients at IPMC's Staten Island, East Brunswick, Perth Amboy, and Tom River office locations. She refers these patients to Dr. Poonia for surgical procedures such as epidurals or corticosteroid injections at IPMC's ambulatory surgery centers. These outpatient services, as well as the durable medical equipment and clinical laboratory services that IPMC provided, are "designated health services" (DHS) under the Stark Law. 42 U.S.C. § 1395nn.

138. Dr. Sharma also refers patients for spine or orthopedic surgeries to several doctors who are not employed by IPMC but perform surgeries at IPMC's surgery facilities. The doctors with this arrangement are orthopedic surgeon Dr. James Cozzarelli, spinal surgeons Dr. Joshua Rovner and his partner, Dr. Kevin Finnessy, and spinal surgeon Dr. Steven Schiebert.

139. Through this arrangement, IPMC receives a facility fee when these surgeons performed surgeries at IPMC's facilities, while the surgeons receive their professional fees from the procedures. Thus, IPMC and Dr. Poonia receive revenues from these outside referrals as well.

140. Under the Stark Law, a physician or immediate family member may not refer patients for designated health services to an entity that they or their family member has a direct or indirect financial relationship with, unless the arrangement falls into one of the exceptions to the Stark Law. 42 U.S.C. § 1935nn(a); 42 C.F.R. § 411.350(a).

141. The Stark Law contains an exception for "physician services" performed by a doctor who is a member of the same group practice, or under the supervision of a doctor who is a member of the same group practice. 42 U.S.C. § 1935nn(b).

142. The Stark Law also contains an "in-office ancillary services" exception for services personally performed by the referring physician or a physician of the same group practice, where, among other requirements, that service is performed in a building where the referring physician or their group practice provide services unrelated to the DHS, or where the patient receiving the DHS usually receives physician services from the referring physician or a member of their group practice. 42 C.F.R. § 411.355(b)(1)-(2).

143. The Stark Law Regulations define a "group practice" as one that "must consist of a single legal entity operating primarily for the purpose of being a physician group practice . . . A group practice operating in more than one State will be considered to be a single legal entity notwithstanding that it is composed of multiple legal entities, provided that . . . The States in which the group practice is operating are contiguous (although each State need not be contiguous to every other State)." 42 C.F.R. § 411.352(a)(1).

144. Because IPMC consists of multiple legal entities and has an office in Texas, which is clearly not contiguous to New York and New Jersey, IPMC does not qualify as a bona fide group practice under the Stark Law's definition.

145. Furthermore, services referred from Dr. Sharma to Dr. Poonia and those non-IPMC doctors using IPMC's ambulatory surgical facilities are not performed in the same building or office in which Dr. Sharma practices. Dr. Sharma practices in IPMC's various office facilities, while the surgical procedures are carried out in IPMC's surgical facilities. In addition, patients would not usually receive physician services in the surgical facilities.

146. These prohibited self-referrals are not excepted from the Stark Law by either the physician services or in-office ancillary services exceptions.

147. Violations of the Stark Law can form the basis for violations of the False Claims Act. *See e.g., U.S. ex rel. Baklid-Kunz v. Halifax Hosp. Med. Ctr.*, No. 6:09-cv-1002-Orl-31DAB, 2012 U.S. Dist. LEXIS 36304, at *8 (M.D. Fla. Mar. 19, 2012), citing *U.S. ex rel. Schmidt v. Zimmer, Inc.*, 386 F.3d 235, 243 (3d Cir. 2004).

148. By having his wife refer patients to his own facilities, Dr. Poonia and IPMC submit or cause the submission of false claims to government payors. IPMC's patients referred to surgical centers through transactions prohibited under Stark include Medicare and Medicaid patients, patients insured by the state-funded workers' compensation funds of New York and New Jersey, and patients insured by the City of New York.

C. Defendants Offer Kickbacks to Employees and Patients to Induce Medicare Business

1. Defendants Pay Employees Kickbacks Per Procedure

149. Defendants pay cash bonuses to their employees in exchange for arranging patients to undergo procedures at IPMC's surgical facilities.

150. For some procedures such as injections, Defendants pay doctors and physicians' assistants a cash bonus per individual procedure performed.

151. Dr. Poonia expects physician assistants to push patients into agreeing to procedures like injections or surgeries, especially if the patients are unsure. Paying cash

bonuses per patient incentivizes physician assistants to do so. Dr. Poonia offered a $500 bonus for scheduling orthopedic procedures and $1000 bonus for spinal surgeries.

152. On one instance, Dr. Poonia informed Relator Reyes that he would receive a $1,000 bonus per patient for those patients that Relator Reyes could bring to the operating table for spinal surgery. Later, Dr. Poonia revised this amount to $100-200 per patient.

153. IPMC tracks the patients that each employee schedules for procedures, in order to pay out bonuses to doctors and physician assistants for each procedure booked or performed.

154. Paying doctors cash bonuses for referrals constitutes an improper referral prohibited by the Stark Law. The Stark Law prohibits physicians from referring DHS to entities that the physician has financial interest in, such as the physician's employer.

155. While the Stark Law excepts bona fide employment compensation relationships, in order to be a bona fide compensation arrangement, the amount paid to the physician must not be "determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician." 42 C.F.R. § (c)(2)(ii).

156. The AKS, which applies to providers like medical assistants and physicians' assistants in addition to doctors, also contains a safe harbor for "any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services." 42 U.S.C. § 1320a-7b(b)(3)(B).

157. The statute or regulations do not clarify that this safe harbor is limited to compensation not determined by the volume or value of referrals. However, in advisory opinions the OIG has suggested that this AKS safe harbor may exclude situations where an employer is paid based on a referral instead of on the actual "provision of covered items or services." *See, .e.g.*, OIG Advisory Opinion No. 12-08 (June 22, 2012)

(physician in question would be bona fide employee because he would be compensated for "furnishing a service for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care program"); OIG Advisory Opinion No. 04-09 (July 25, 2004) (concluding that "The anti-kickback statute disfavors payment structures that tie compensation, even for services, to patients referred by the compensated party" but "where such payments are made through an employment relationship specifically deemed bona fide by the IRS, the arrangement is protected despite the risk it otherwise presents of fraud and abuse."); OIG Advisory Opinion No. 00-02 (April 4, 2000) (approving a proposed arrangement partially on the grounds that it "will not reward suggestions that specify, directly or indirectly, a particular vendor.").

158. Pursuant to the Affordable Care Act passed in 2010, claims submitted to a federal health care program that includes items or services resulting from violations of the AKS constitutes a false or fraudulent claim for purposes of the False Claims Act. 42 U.S.C. § 1320a-7b(g). By paying employees cash bonuses when patients receive certain procedures at IPMC, Dr. Poonia and IPMC submit or cause the submission of false claims to government payors. IPMC's patients referred through illegal transactions in violation of the AKS include Medicare and Medicaid patients, patients insured by the state-funded workers' compensation funds of New York and New Jersey, and patients insured by the City of New York.

2. Defendants Give Kickbacks to Patients Through Waiver of Copays and Deductibles and Providing Free Transit

159. To incentivize patients to choose IPMC as their provider when it is not an in-network provider, IPMC regularly waives copays and deductibles for patients, including Medicare and other government-insured patients. IPMC also provides Medicare patients with free transit to procedures when it financially benefits IPMC.

160. In or around 2016, IPMC implemented a sham payment plan scheme to avoid scrutiny for waiving copays and deductibles. Patel instructs staff, including

Relators, to have patients sign a payment plan for paying off their deductible or copay. The payment plan is for a very low amount, such as $10 per office visit. However, IPMC does not attempt to collect the remaining balance. Consequently, IPMC absorbs most of patients' unpaid deductible or copay, while the sham payment plan allowed IPMC to make it look as though it may collect the amount in case Medicare or another insurance conducts an audit.

161. IPMC waives copays and deductibles as part of its strategy to steer patients towards its services, in part because excepting Medicare, the workers' compensation insurers, and no-fault insurers, IPMC does not have in-network contracts, making it an out of network provider for most insurances.

162. IPMC intentionally remains out of network because the reimbursement received as an out of network provider is higher than network fee schedules with insurers would be. Dr. Poonia's strategy is to increase revenue by charging out of network prices while absorbing the cost of a patient's deductible, which is usually covered by the cost of one procedure at one of IPMC's ambulatory surgery facilities. Once the patient's deductible has been exceeded, Dr. Poonia books the patient for as many more procedures as possible during the year, allowing him to bill for these procedures at a higher out of network rate. Waiving a patient's deductible incentivizes patients to continue using IPMC as their provider even though IPMC is out of network.

163. As an OIG Special Fraud Alert on the Routine Waiver of Copayments or Deductibles under Medicare Part B explains, routine waiver of deductibles and copayments by charge-based providers (as opposed to cost-based or capitated providers) is unlawful "because it results in (1) false claims, (2) violations of the anti-kickback statute, and (3) excessive utilization of items and services paid for by Medicare." Publication of OIG Special Fraud Alerts, 59 Fed. Reg. 65372 (Dec. 19, 1994).

164. Because waiving a copay or deductible lowers the actual cost of the item or service, a provider who charges Medicare for the stated cost of the item (for example,

a $100 treatment) while offering it to the patient at a lesser cost due to the waiver of a copayment (for example, waiving a $20 copay, thus making the actual cost $80) is overcharging Medicare for that item or service. *Id.* If Medicare pays 80 percent of the $100 charge instead of 80 percent of the actual cost of $80, then Medicare ends up paying $16 more than it should have for the item, due to the provider's false representations. *Id.*

165. In addition, if a provider offers waiver of copays and deductibles for any reason other than a patient's genuine financial hardship, this may be a violation of the AKS as this practice may unlawfully induce patients to purchase items or services from that provider. *Id.*

166. In addition to paying cash bonuses to employees, Defendants also incentivize patients to undergo procedures by providing free transit to its surgical centers. Defendants specifically target Medicare patients, in violation of the AKS's prohibition against offering or exchanging anything of value to induce or reward the referral of federal health care program business.

167. Defendants use Universal Transportation Service, a New Jersey LLC registered to Dr. Poonia, to provide transportation services to patients. Employees of Universal Transportation are paid through IPMC's payroll.

168. Defendants use the free transit service to encourage patients to undergo surgical procedures. Initially, IPMC offered all patients undergoing procedures at IPMC's surgery centers free transit to the procedures through Universal Transportation Service. However, at a later point, IPMC began offering free transportation only to Medicare patients, and only for procedures where IPMC had determined that the revenue from the procedure merited the cost of providing free transit. For example, IPMC stopped providing transit for patients receiving joint injections, because the reimbursement for injections did not warrant the expense of the transit.

169. Pursuant to the Affordable Care Act passed in 2010, claims submitted to a federal health care program that includes items or services resulting from violations of

the AKS constitutes a false or fraudulent claim for purposes of the False Claims Act. 42 U.S.C. § 1320a-7b(g). By providing patients with kickbacks by waiving deductibles and offering free transit, Dr. Poonia and IPMC submit or cause the submission of false claims to government payors. IPMC's patients who have received remuneration through the waiver of co-pays and free transit include Medicare and Medicaid patients, patients insured by the state-funded workers' compensation funds of New York and New Jersey, and patients insured by the City of New York.

D. Defendants Create and Submit False Documentation to Support False or Fraudulent Claims

170. IPMC staff also change patients' medical documentation submitted to insurance in order to receive reimbursement or justify procedures performed. For example, Practice Administrator Patel—not a clinical provider—sometimes drafts a narrative or summary of care of the patient's visit for a doctor to sign off on, even though that doctor only saw the patient for an initial visit and did not supervise that patient's ongoing care with a physician assistant. Relators personally witnessed Patel prepare summaries of this nature for Dr. Poonia, Dr. Sharma, and Dr. Moten.

171. Relator Reyes also noticed that sometimes his notes on the patient's condition were not accurately reflected by the progress notes sent to patients' insurance. Notes were changed to make the patient seem as though he or she experienced more pain, to receive insurance approval for injections.

172. Angela Mannuzza, IPMC's Office Coordinator, instructs medical assistants—who take progress notes on patients—what to write in the notes. Mannuzza reviews all progress notes taken and sometimes changes the notes to justify the procedures that IPMC wants to perform. Jessica Marquez does the same for New Jersey workers' compensation patients' progress notes.

173. IPMC used eClinicalWorks as its electronic medical records software system. Within this system, IPMC uses templates with prepopulated progress notes intended to help justify procedures.

174. For example, Practice Administrator Patel stated in a July 27, 2015 email that she created an eClinicalWorks template to be used for all patients for justifying precertification for procedures. The template details prior treatment that the patient supposedly had received. She stated that "We have been getting many denials stating that there is no mention of patient trying and failing physical therapy. Most insurances require at least 6 months of failed conservative treatment." Patel also attached four different insurance carriers' policies for staff to read. At one point, Practice Administrator Patel told staff that the templates needed to be changed so as not to raise suspicion with insurance companies because all the notes were the same.

175. Because there are only approximately four employee physicians employed by IPMC at any given time, and approximately twelve locations, IPMC relies heavily on physicians' assistants and medical assistants to examine patients.

176. In order for a physician to bill a service performed by a physicians' assistant as "incident to" the doctor's services, the physician must provide "direct supervision." Medicare Benefit Policy Manual, Chapter 15 § 60.1 Direct supervision, as defined by CMS, requires that a doctor be present in the immediate office suite to render assistance if necessary, although a doctor is not required to be in the treatment room at the time of the service. *See* CMS, MLN Matters Number SE0441, "Incident to" Services (revised Aug. 23, 2016) https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf.

177. As there are not enough doctors to be present at all the office locations at one time, physicians' assistants see patients without direct supervision. Physicians, including Dr. Poonia and Dr. Moten, bill for these services as "incident to" their NPI numbers, even though they do not directly supervise the physicians' assistants.

178. Since approximately 2011, Defendants have submitted and/or caused the submission of false claims with false documentation of the patient's symptoms and false claims representing supervision of physician assistants to Medicare and other government payors including those of the States of New Jersey, the State of New York, and the City of New York. Defendants have done so in violation of the federal False Claims Act, and the False Claims Acts of New Jersey and New York. Defendants have also violated the federal Stark Law and AKS.

VII. CAUSES OF ACTION

Count I

False Claims Act

31 U.S.C. §§ 3729(a)(1)(A)-(B), (G)

179. Relators reallege and incorporate by reference the allegations contained in paragraphs 1 through 178 above as though fully set forth herein.

180. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. § 3729, *et seq.*, as amended.

181. Defendants knowingly have caused the presentation of false or fraudulent claims for payment to the United States, in violation of 31 U.S.C. § 3729(a)(1)(A).

182. Defendants have knowingly made, used, or caused to be made or used, a false record or statement material to a false or fraudulent claim to the United States, in violation of 31 U.S.C. § 3729(a)(1)(B).

183. Defendants knowingly made, used, or caused to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly concealed or knowingly and improperly avoided or decreased an obligation to pay or transmit money or property to the Government, in violation of 31 U.S.C. § 3729(a)(1)(G).

184. The United States Government, unaware of the falsity of the claims that Defendants caused to be made, paid and continues to pay the claims that would not be paid but for Defendants' illegal conduct.

185. Defendants have damaged, and continue to damage, the United States in a substantial amount to be determined at trial.

186. Additionally, the United States is entitled to the maximum penalty for each and every violation alleged herein.

Count II

New York False Claims Act

N.Y. State Fin. §§ 189(1)(a)-(b), (g), (h)

187. Relators reallege and incorporate by reference the allegations contained in paragraphs 1 through 178 above as though fully set forth herein.

188. This is a claim for treble damages and penalties under the New York False Claims Act.

189. Defendants knowingly presented, or caused to be presented, false or fraudulent claims to the New York State Government for payment or approval.

190. By virtue of the acts described above, Defendants knowingly concealed and improperly avoided or decreased an obligation to pay money to the New York State Government.

191. Defendants knowingly made, used, or caused to be made or used false records and statements, and omitted material facts, to induce the New York State Government to approve and pay such false and fraudulent claims.

192. The New York State Government, unaware of the falsity of the records, statements, and claims that Defendants made or caused to be made, paid and continues to pay the claims that would not be paid but for Defendants' illegal conduct.

193. Defendants have damaged, and continues to damage, the State of New York in a substantial amount to be determined at trial.

194. Additionally, the New York State Government is entitled to the maximum penalty for each and every violation alleged herein.

Count III

New Jersey False Claims Act

N.J. Stat. §§ 2A:32C-3(a)–(b), (g)

195. Relators reallege and incorporates by reference the allegations contained in paragraphs 1 through 178 above as though fully set forth herein.

196. This is a claim for treble damages and penalties under the New Jersey False Claims Act.

197. Defendants knowingly presented, or caused to be presented, false or fraudulent claims to the New Jersey State Government for payment or approval.

198. By virtue of the acts described above, Defendants knowingly concealed and improperly avoided or decreased an obligation to pay money to the New Jersey State Government.

199. Defendants knowingly made, used, or caused to be made or used false records and statements, and omitted material facts, to induce the New Jersey State Government to approve and pay such false and fraudulent claims.

200. The New Jersey State Government, unaware of the falsity of the records, statements, and claims that Defendants made or caused to be made, paid and continues to pay the claims that would not be paid but for Defendants' illegal conduct.

201. Defendant has damaged, and continues to damage, the State of New Jersey in a substantial amount to be determined at trial.

202. Additionally, the New Jersey State Government is entitled to the maximum penalty for each and every violation alleged herein.

VIII. PRAYER

WHEREFORE, Relators pray for judgment against Defendants as follows:

203. That Defendants cease and desist from violating the False Claims Act, 31 U.S.C. § 3729 *et seq*., The New York False Claims Act, N.Y. State Fin. §§ 189(1)(a)-(b), (g), (h), and the New Jersey False Claims Act, N.J. Stat. §§ 2A:32C-3(a)–(b), (g);

204. That this Court enter judgment against Defendants in an amount equal to three times the amount of damages the United States and the States of New York and New Jersey have sustained because of Defendants' actions, plus the maximum civil penalty permitted for each violation of the Federal False Claims Act, the New York False Claims Act, and the New Jersey False Claims Act;

205. That Relators be awarded the maximum amount allowed pursuant to § 3730(d) of the False Claims Act and the equivalent provisions of the New York False Claims Act and New Jersey False Claims Act;

206. That Relators be awarded all fees, costs, and expenses incurred in connection with this action, including attorneys' fees, costs, and expenses; and

207. That Relators recover such other relief as the Court deems just and proper.

IX. DEMAND FOR JURY TRIAL

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Relators hereby demands a trial by jury.

Dated: September 17, 2018

Respectfully submitted,

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