IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF KENTUCKY

THE UNITED STATES OF AMERICA,
ex rel. [UNDER SEAL],

Plaintiffs,

v.

[UNDER SEAL],

Defendants.

UNDER SEAL

Qui tam action filed in camera and under seal in accordance with 31 U.S.C. § 3730(b)(2)

Civil Action No. 1:19-CV-171-GNS

COMPLAINT

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF KENTUCKY

THE UNITED STATES OF AMERICA, *ex rel.* LAURA COLE and TIFFANY SAYLOR,

Plaintiffs,

v.

MEDOPTIONS OF KENTUCKY, LLC, and MEDITELECARE,

Defendants.

UNDER SEAL

Qui tam action filed in camera and under seal in accordance with 31 U.S.C. § 3730(b)(2)

Civil Action No. 1:19-cv-171-GNS

COMPLAINT

TABLE OF CONTENTS

1. Plaintiff-relators Laura Cole and Tiffany Saylor (together, "Relators") bring this action on behalf of the United States of America against MedOptions of Kentucky, LLC, and MediTelecare (together, "MedOptions" or the "Defendants") for violations of the Federal False Claims Act, 31 U.S.C. §§ 3729 et seq. (the "FCA"), to recover all damages, civil penalties and all other recoveries provided for under this statute.

I. INTRODUCTION

2. MedOptions has defrauded Medicare and Medicaid by billing for remotely-delivered behavioral health services to nursing home residents that it did not in fact provide. MedOptions concealed its fraud by falsifying patient records to reflect more and different treatment than it delivered. Furthermore, it has routinely violated HIPAA thereby depriving patients of the privacy protections their medical and treatment histories must be given under that statute. Accordingly, MedOptions has violated Medicare and Medicaid legal requirements for reimbursement in multiple respects. From a policy perspective, it has effectively undermined the government's efforts to expand treatment to patients in rural areas through the use of legitimate telemedicine services.

3. In many cases, the MedOptions nurse practitioner that was scheduled to provide remote psychotherapy treatments and medication management services to nursing home residents in western Kentucky would not participate in the scheduled sessions and instead directed Relator Saylor, a MedOptions "Facilitator" who was not licensed or otherwise qualified to provide psychotherapy, to ask a handful of basic questions to the patient so that MedOptions could falsely represent that a full, 25-minute session was provided. In other instances, when patients at these facilities congregated for social group activities, the MedOptions nurse

practitioner would direct Relator Saylor to simply point the video equipment at multiple patients at a time so that MedOptions could claim that telehealth services were provided to each of them.

4. Even in those situations where the MedOptions licensed practitioner was present for a scheduled one-on-one session with a patient, often that practitioner would themselves only ask three questions: "how have you been sleeping?", "how have you been eating?," and "have you been depressed?", prompting a brief exchange with the patients that took just a few minutes. The practitioner would then claim that a full, 25-minute session was provided.

5. At the same time that MedOptions was failing to provide appropriate mental health treatment, it was manipulating patients' records to represent that they were not progressing towards their goals in order to justify continued treatment and reimbursement from the government healthcare programs. MedOptions' practice was to keep patients in psychotherapy treatment indefinitely, and very often patients were only discharged after they or a family member complained about MedOptions' ineffectual services.

6. These therapy sessions were scheduled for the treatment of patients' mental health conditions and were used to effectuate the plan of care that included both psychotherapy and the administration of anti-psychotic medication. MedOptions' failure to provide medically appropriate treatment not only defrauded the government healthcare programs but has put these patients at serious risk of developing further mental health conditions.

II. JURISDICTION & VENUE

7. Jurisdiction is founded upon the FCA, 31 U.S.C. §§ 3729 *et seq*., specifically 31 U.S.C. §§ 3732(a) & (b) and also 28 U.S.C. §§ 1331 and 1345. The Court may exercise personal jurisdiction over Defendants because they transact business in this District and are engaging in the alleged illegal activities and practices in this District.

8. Venue in the Western District of Kentucky is appropriate under 31 U.S.C. § 3732(a), in that many of the acts complained of took place in this District.

III. PARTIES

9. The United States is a real party in interest to the claims in this action. Through the Department of Health and Human Services ("HHS") and the Centers for Medicare & Medicaid Services ("CMS"), the United States administers the Medicare and Medicaid programs.

10. Relator Saylor was employed by MedOptions from approximately November 2016 until June 2018. She was previously a Outpatient Psychiatry Manager and a Medical Assistant at the Graves Gilbert Clinic from 2015 to 2016, and an Outpatient Office Manager at Rivendell Behavioral Health Hospital from 2011 to 2015, both in Bowling Green, Kentucky. Earlier in her career, Relator Saylor worked in medical billing for seven years at Tristar Greenview Regional Hospital, also in Bowling Green, Kentucky.

11. While Relator Saylor has extensive professional experience in medical billing and the healthcare industry generally, she has no license or other credential that would qualify her to provide medication management or other behavioral health services.

12. Relator Saylor's position with MedOptions was referred to as a "Facilitator," and she was responsible for being on-premises at certain nursing homes in Kentucky and arranging the physical equipment at those facilities (such as a cart with a laptop, video camera, and speaker) in front of patients to enable telemedicine consultations. When directed, she would also position the videoconferencing equipment to permit remote MedOptions employees to speak with facility staff.

13. At any given time, Relator Saylor worked with one of two MedOptions nurse practitioners and also one MedOptions psychologist. The two nurse practitioners were Lisamarie Pietragallo who lives in Pennsylvania, and Barbara Hignite who lives in Kentucky.

14. Relator Saylor covered three facilities for MedOptions during the course of her employment, going to different facilities on different days of the week. These facilities were Beaver Dam Nursing and Rehabilitation Center ("Beaver Dam," located at 1595 US-231, Beaver Dam, KY 42320), NHC Glasgow (109 Homewood Blvd., Glasgow, KY 42141), and Diversicare of Glasgow (300 Westwood Street, Glasgow, KY 42141).

15. Upon information and belief, MedOptions nurse practitioners Pietragallo and Hignite were responsible for providing remote mental health services to patients in nursing facilities in addition to those at which Relator Saylor worked, including states besides Kentucky.

16. At Beaver Dam, MedOptions was treating approximately 30 patients at any time and scheduled approximately 25 patient encounters per week. Relator Saylor would arrive at Beaver Dam at 8:45 a.m. and typically concluded MedOptions' patient encounters before 11 a.m. This very short workday was a result of the nurse practitioners wishing to finish their days early.

17. Relator Saylor had approximately 100-125 encounters per week across her three facilities, approximately 50-60 of which were with nurse practitioners.

18. Relator Cole has been the Administrator of Beaver Dam Nursing and Rehabilitation Center as its Administrator since 2014. In this role, Relator Cole is responsible for leading and directing the overall operations of the facility, including the hiring and training of facility staff, monitoring each operational function of the facility, and ensuring that resident needs are addressed.

19. Beaver Dam is one of at least six facilities owned or operated by Doug Cox and managed by his affiliated company, Providence Health Group. Other facilities owned by Mr. Cox and managed by Providence Health Group are located in Kentucky, Ohio, West Virginia, Wisconsin, and North Carolina. Relator Cole reports to Steve Nee, Vice President of Operations at Providence Health Group.

20. Beaver Dam has 58 beds, all of which are certified both for Medicare Skilled Nursing Facility and Medicaid Nursing Facility status.

21. Since approximately 2017, Beaver Dam has contracted with MedOptions to provide "synchronous, interactive, clinical audio and video teleconsultation behavioral health services" to its residents. Beaver Dam's contract with MedOptions provides that MedOptions will comply with the False Claims Act, the Elder Justice Act, and the Health Insurance Portability and Accountability Act ("HIPAA") and will be responsible for all Medicare and Medicaid billing relating to its services. These services are to consist of "synchronous, interactive, clinical audio and video teleconsultation behavioral health Services to Residents…."

22. Defendant MedOptions of Kentucky, LLC is a Delaware limited liability company with its principal place of business located at 169 Main Street, 800 Plaza Middlesex, Middletown, CT 06457, and a primary practice address at 421 W. Main Street, Frankfort, Kentucky 40601.

23. MedOptions is a large, privately-held company that describes itself as "the nation's leading provider of behavioral health services to skilled nursing facilities." *See* MedOptions website at https://www.medoptionsinc.com/. MedOptions is currently owned by two private equity firms, Summit Partners and Point Judith Capital. Summit Partners is active in

the healthcare industry and advertises its ability to "improve operational efficiency" and "grow revenues" in its portfolio companies. Summit Partners has three board seats on MedOptions.[1]

24. MedOptions also has established the following limited liability companies that have National Provider Identifiers ("NPI") with CMS: MedOptions Behavioral Health Associates, LLC; MedOptions of Georgia, LLC; MedOptions of Maine, LLC; MedOptions of Massachusetts, LLC; MedOptions of New Hampshire, LLC; MedOptions of Ohio, LLC; and MedOptions of Vermont, LLC.

25. MedOptions has a telehealth division called "MedOptions TeleHealth," and markets this business to, among other providers, skilled nursing facilities, as a way to decrease reliance on antipsychotic medications and thereby increase a facility's Medicare nursing home ranking.

26. On or around January 1, 2018, MedOptions created a new division called "MediTelecare," but at that time did not make any associated changes to its operations and provision of telehealth services. MedOptions told its employees that going forward MedOptions would focus on in-person services and MediTelecare would operate its telehealth business.

27. At present, MediTelecare operates as a nominally separate private company with a mailing address of MediTelecare, P.O. Box 1595, Middletown, CT 06457-1595. Its website indicates that it was founded by former MedOptions CEO Ed Mercadante. (*See* https://www.meditelecare.com/about-us/executive-team/).

28. MediTelecare presently operates in at least the following states: Vermont, Maine, New Hampshire, Kentucky, Ohio, Virginia, Iowa, Texas, Mississippi, Kansas, West Virginia, Nebraska, Missouri, Minnesota, and Oklahoma.

---

[1] *See* Summit Partners Website at https://www.summitpartners.com/how-we-help#tab-8.

IV. LEGAL BACKGROUND

A. The False Claims Act

29. The FCA imposes liability on 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; [or]

* * *

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government[.]

31 U.S.C. §§ 3729(a)(1)(A), (B) & (G).

30. The term "knowingly" means "that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information." 31 U.S.C. § 3729(b)(1)(A). Proof of specific intent to defraud is not required. See 31 U.S.C. § 3729(b)(1)(B).

31. Section 3729(a)(1) of the FCA provides that a person is liable to the United States Government for three times the amount of damages that the Government sustains because of the act of that person, plus a civil penalty of $5,000 to $10,000 per violation. Pursuant to the Civil Penalties Inflation Adjustment Act of 1990, as amended by the Debt Collection Improvement Act of 1996, 28 U.S.C. § 2461 (note), 64 Fed. Reg. 47099, 47103 (1999), and 28 C.F.R. § 85.3 (2015), the FCA civil penalties were adjusted to $5,500 to $11,000 per violation for violations occurring on or after October 23, 1996. In accordance with the Federal Civil Penalties Inflation Adjustment Act of 2015, those same FCA civil penalty amounts were made applicable to all violations occurring on or before November 2, 2015. *See* 28 C.F.R. §§ 85.3 & 85.5 (2016); 81

Fed. Reg. 42491, 42500 (2016). In accordance with the Bipartisan Budget Act of 2015, 28 U.S.C. § 2461 (note) (2015), the Department of Justice has annually adjusted the penalties applicable to violations occurring after November 2, 2015 and assessed or enforced after August 1, 2016. As of the filing of this Complaint, the FCA civil penalty amounts have been adjusted for violations occurring after November 2, 2015 and assessed or enforced after January 29, 2018 to $11,181 to $22,363 per violation. 28 C.F.R. § 85.5 (2018).

32. The federal government pays the majority of Kentucky's Medicaid costs. As of the most recent (fiscal year 2019) rulemaking, the Federal Medical Assistance Percentage for Kentucky is 71.82%. Accordingly, the state of Kentucky is a "grantee" of federal funds pursuant to 31 U.S.C. § 3729(b)(2) and false claims submitted to Kentucky's Medicaid program are violations of the federal false claims act.

B. Medicare and Medicaid Coverage and Reimbursement for Psychotherapy Services

33. Medicare is a federal program that provides subsidized health insurance for persons who are 65 or older or are disabled. *See* 42 U.S.C. §§ 1395 et seq. Part A of the Medicare program provides coverage for inpatient hospital treatment. Part B of the Medicare program provides supplemental benefits to participants to cover, among other things, certain physician services such as doctor's visits provided in an office or remotely. *See generally id.* §§ 1395j–1395w-4. Part C of the Medicare program provides for Medicare Advantage plans that cover at least the benefits that are covered by Parts A and B.

34. Medical services provided remotely using real-time videoconferencing technology are referred to as "telemedicine" or "telehealth services." In recent years, Medicare has purposefully expanded the range of telemedicine services that it covers in an effort to expand the services available to patients in rural areas. *See* Section 1834(m) and 42 C.F.R. §

410.78. This benefit was added in 2001 and by 2013 expenditures had grown to over $11 million annually.[2] Medicare telehealth expenditures were $17.6 million in 2015, and are expected to increase significantly in future years.[3]

35. Medicare has specific rules that apply when covered services are provided remotely rather than in-person. Relevant coverage parameters are found in Medicare Claims Processing Manual, Ch. 12 § 190 ("Medicare Payment for Telehealth Services"). It is generally required that covered services such as office visits, consultations, and psychiatry services are furnished using an interactive audio-visual telecommunications system that permits real-time communication.

36. Medicare only covers telehealth services that are furnished to a beneficiary who is present in an "originating site" located in certain geographic areas: a rural health professional shortage area (HPSA), a county outside of a Metropolitan Statistical Area (MSA), or a site that is participating in a Federal telehealth demonstration project. Only the following settings qualify as originating sites: physicians' offices, hospitals, rural health clinics, federally qualified health centers, skilled nursing facilities, and community mental health centers.

37. Medicare only covers telehealth services provided by certain practitioners: physicians, nurse practitioners, physician assistants, nurse-midwives, clinical nurse specialists, certified registered nurse anesthetists, clinical psychologists, clinical social workers, and registered nutrition professionals.[4]

---

[2] "Medicare Telehealth Policy," gpTRAC Regional Telehealth Forum (Apr. 6, 2015), at slide 8.

[3] *CMS Paid Practitioners for Telehealth Services That Did Not Meet Medicare Requirements*, A-05-16-0058 (Apr. 2018).

[4] Relator Saylor is not a covered practitioner for Medicare telehealth services.

38. The telehealth practitioner is paid by Medicare at the same rate as if the service was provided in person. The originating site is paid a fee of approximately $25 per session.

39. Medicare updates annually a list of services that it covers when provided remotely. This list currently includes the following services, among others:

CY 2019 Medicare Telehealth Services

Service	HCPCS/CPT Code
Office or other outpatient visits	99201–99215
Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days	99231–99233
Individual psychotherapy	90832–90838
Telehealth Pharmacologic Management	G0459
Psychiatric diagnostic interview examination	90791–90792

40. Among the services covered by Medicare are "evaluation and management" ("E/M") visits in which a patient is seen by a doctor in an outpatient setting for the treatment of a medical condition.

41. There are five levels of new and established patient E/M visits, corresponding to the level of complexity of the evaluation and consideration of treatment options. Medicare has published extensive guidance on the requirements for billing at each level.[5]

42. For E/M visits in which counseling and/or coordination of care composes more than 50% of the face-to-face time in the encounter, the amount of face-to-face time is the controlling factor in determining the proper billing code, and therefore the proper reimbursement amount, for that service.

[5] These sources include the *1995 Documentation Guidelines for Evaluation and Management Services*, the *1997 Documentation Guidelines for Evaluation and Management Services*, CMS Publication 100-04, Ch. 12, § 30.6 (Evaluation and Management Service Codes), and various LCDs (see e.g., L36230 (Evaluation and Management Services in a Nursing Facility).

43. The E/M codes for outpatient services are listed below, along with the standard (average) lengths of time relating to each.

Outpatient – New					
Codes	99201	99202	99203	99204	99205
Times	10 min.	20 min.	30 min.	45 min.	60 min.
Outpatient – Established					
Codes	99211	99212	99213	99214	99215
Times	5 min.	10 min.	15 min.	25 min.	40 min.
Outpatient – Consultation					
Codes	99241	99242	99243	99244	99245
Times	15 min.	30 min.	40 min.	60 min.	80 min.

44. As for psychotherapy services in particular, Medicare covers these services both when provided alongside an E/M service and when provided separately. "Psychotherapy is defined as the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development or support current evaluation of functioning." Local Coverage Determination (LCD): Psychiatry and Psychology Services (L34616).

45. Medicare coverage for psychotherapy services is premised on compliance with express requirements, including:

- "Prolonged treatment must be well supported by the content of the medical documentation. Documentation must be present in the medical record supporting the medical necessity for ongoing treatment." *Id.*

- "When stability can be maintained without further treatment or with less intensive treatment, the psychological services are no longer medically necessary." L26895.

- "There are no specific limits on the length of time that services may be covered ….As long as the evidence shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice, coverage may be continued CMS Publication 100-02, Medical Benefit Policy Manual (MBPM), Ch. 6 § 70.1.

- "When a patient reaches a point in his/her treatment where further improvement does not appear to be indicated and there is no reasonable expectation of improvement, the outpatient psychiatric services are no longer considered reasonable or medically necessary." L26895.

- Coordination of care services must be provided "in the presence of the patient," "at the bedside or on the patient's hospital floor" in order for time spent on that task to be included when determining the level of service that should be billed to Medicare. MCPM § 30.6.1.C.

46. Psychiatric services will not be considered medically reasonable or necessary where "services are provided to individuals who have limited cognitive ability and therefore may not benefit from the psychiatric intervention." Medicare Payments for Psychiatric Services in Nursing Homes," Department of Health and Human Services, Office of Inspector General (January 2001). In addition, "[s]evere and profound intellectual disability (mental retardation, ICD-9 codes 318.1, 318.2, 319) is never covered for psychotherapy services," and "[s]ervices are not covered when documentation indicates that dementia has produced a severe enough cognitive defect to prevent psychotherapy from being effective." CMS Fact Sheet, Outpatient Psychiatry & Psychology Services, LCD 34353 (Jan. 27, 2016). "Psychotherapy services are not covered when documentation indicates that dementia has produced a severe enough cognitive defect to prevent establishment of a relationship with the therapist which allows insight-oriented, behavior-modifying or supportive therapy to be effective." L34616.

47. With regard to the provision of psychotherapy services billed under codes 90832-90838, CMS has published a MLN Matters Special Edition Article (SE1407, re-issued Mar. 18, 2014), reaffirming the time-related billing requirements for these services, in particular that time providing psychotherapy services must be billed separately from time directed to E/M:

> *The main error that CERT has identified with the revised psychiatry and psychotherapy codes is not clearly documenting the amount of time spent only on psychotherapy services. The correct E&M code selection must be based on the elements of the history and exam and medical decision making required by the complexity/intensity of the patient's condition. The psychotherapy code is chosen on the basis of the time spent providing psychotherapy.*
> ***
> *Because time is indicated in the code descriptor for the psychotherapy CPT codes, it is important for providers to clearly document in the patient's medical record the time spent providing the psychotherapy service rather than entering one time period including the E&M service.*
> ***
> *For psychotherapy services provided without an E&M service, the correct code depends on the time spent with the beneficiary.*
>
> • *Code 90832: Psychotherapy, 30 minutes with patient and/or family member*
> • *Code 90834: Psychotherapy, 45 minutes with patient and/or family member*
> • *Code 90837: Psychotherapy, 60 minutes with patient and/or family member*
>
> *In general, providers should select the code that most closely matches the actual time spent performing psychotherapy. CPT® provides flexibility by identifying time ranges that may be associated with each of the three codes:*
>
> • *Code 90832 (or + 90833): 16 to 37 minutes,*
> • *Code 90834 (or + 90836): 38 to 52 minutes, or*
> • *Code 90837 (or + 90838): 53 minutes or longer*
>
> *Do not bill psychotherapy codes for sessions lasting less than 16 minutes.*

48. In addition, like all providers, telemedicine providers must adhere to HIPAA and other legal requirements that ensure the safety and confidentiality of patients' personal health information.

49. State Medicaid programs will typically cover Medicare copayments for their beneficiaries and may also cover telemedicine services beyond those covered by Medicare. Federal law allows states to reimburse for telehealth services under Medicaid as long as they satisfy basic requirements of efficiency, economy, and quality of care.

50. Kentucky Medicaid generally covers telehealth services in the same manner as in-person services, except where in-person services are expressly required. Kentucky has the tenth-highest number of Medicare beneficiaries receiving telehealth services in the nation.

51. "The department shall reimburse a telehealth provider who is eligible for reimbursement from the department for a telehealth consultation an amount equal to the amount paid for a comparable in-person service." 907 KAR 3:170 § 5(1)(a).

V. FACTUAL ALLEGATIONS

A. Defendants Billed the Government Healthcare Programs for Telehealth Services That They Did Not Provide

52. In order to qualify for reimbursement all claims for the provision of E/M, psychotherapy, and medication management services must be provided by a licensed professional, be medically necessary, and satisfy all other Medicare and Medicaid requirements. MedOptions routinely satisfies none of these prerequisites for claims that it submits to Medicare and Medicaid.

53. Throughout the relevant time period, it was frequently the case that a MedOptions nurse practitioner was unavailable during the scheduled time for a patient session. In such instances, the nurse practitioner directed Relator Saylor to stand in for the nurse practitioner and ask three questions, an exercise that resulted in a very brief exchange with the scheduled patient. On this basis, MedOptions would then claim that a full session was provided and bill the government healthcare programs accordingly.

54. During the entirety of Relator Saylor's employment with MedOptions, she was directed to perform the responsibilities of the nurse practitioner and interact with the patients in their place approximately 5 to 10 times each week, and this occurred at all three locations at which she worked.

55. Nurse practitioners Pietragallo and Hignite directed Relator Saylor to ask patients in their absence: "how have you been sleeping?", "how have you been eating?", and "have you been depressed?"

56. In some cases, the MedOptions nurse practitioners would tell Relator Saylor that they were going to lunch and that she should "try to find someone to talk to" that could be billed as a full visit.

57. Relator Saylor was not directed to ask any follow-up questions regardless of the patients' answers to those three questions. Relator Saylor eventually came to know some of these patients and would sometimes engage them in conversation to be kind, but this informal discussion was not related to any clinical care. In any event, these informal "visits" did not involve any use of videoconferencing equipment.

58. Relator Saylor was then told to transmit the patients' responses in "yes/no" format to the nurse practitioners. Relator Saylor was asked only to transmit a few words to summarize the encounter and there was never a phone call with the nurse practitioners after each "visit." Instead, Relator Saylor was told to communicate these "yes/no" answers to the nurse practitioners in text messages using her cellphone.

59. In other instances, patients were engaged in group social activities in common areas of their nursing facility during the time of their scheduled appointment. This was a very frequent occurrence at Beaver Dam, which had an usually high number of social activities for its

residents. At other facilities, Relator Saylor encountered this situation when residents were having meals in groups, for instance.

60. When this occurred, the MedOptions nurse practitioner would direct Relator Saylor to merely "point the screen" at one or more patients in the group. No substantive interaction occurred between the nurse practitioner and patients during these encounters, but they were treated by MedOptions as full therapy sessions for reimbursement purposes.

61. In order for a telemedicine encounter to occur, the video equipment must permit real-time visual and audio interaction of the participants. Medicare Claims Processing Manual, Ch. 12 § 190.4(1). In many instances, MedOptions' videoconferencing equipment would not function properly and would only show a black screen in place of video transmission. MedOptions would always continue with the "session" even if videoconferencing did not occur and even when the MedOptions practitioner could neither see nor hear the patient.

62. These malfunctions were a frequent occurrence, particularly at the Diversicare of Glasgow and NHC Glasgow nursing facilities, where the internet connection rarely permitted videoconferencing. The MedOptions nurse practitioners would then ask Relator Saylor to initiate a regular call on her personal cellphone to ask their few questions of these patients.

63. When the videoconferencing equipment did not function properly, even having a short conversation with a patient was challenging. Patients with impaired mental function were often confused as to whom they were speaking with. Some patients were unable to speak effectively at all, and these "visits" in particular were medically worthless when the nurse practitioner could not see the patient.

64. It is a condition of coverage that behavioral health treatment be administered in a manner that includes legitimate interaction between the practitioner and patient, and therefore

requires that the patient have sufficient mental capability to recognize that a discussion is occurring and participate in their own treatment.

65. In violation of this requirement, MedOptions would visit with patients that suffered from mental conditions that rendered them entirely nonresponsive, including those who were unaware that they were being spoken to during sessions or were asleep for some or all of a "visit."[6]

66. It was Relator Saylor's experience that the frequency of scheduled visits was determined by the nurse practitioner's desire for a full schedule since MedOptions currently pays nurse practitioners based on how many visits they complete. Nurse practitioners would remark to Relator Saylor that they needed to schedule more appointments before they took vacation, for instance.

67. As a result of the conduct described herein, MedOptions fraudulently billed Medicare for services that were not rendered and deprived patients of legitimate and necessary services for the management of their mental health conditions and the appropriateness of their medication regimen.

B. Defendants Billed the Government Healthcare Programs for Telehealth Services Typically of 25 Minutes or More Despite Only Speaking with Patients for 5 Minutes or Less

68. When MedOptions nurse practitioners did establish videoconferencing contact with patients, their "treatment" was largely perfunctory, extremely short in duration, and ineffective to deliver competent medical care. These short, "assembly line" visits were

[6] Relators have provided lists of certain such patients from multiple facilities to the Department of Justice.

completed as quickly as possible and yet MedOptions would typically bill Medicare for 25 minute encounters.

69. The two nurse practitioners with whom Relator Saylor worked would typically speak with patients for only 3-5 minutes per session, and would ask the same basic three questions, such as "are you feeling depressed or anxious? are you eating? are you sleeping?"

70. Regardless of the patients' responses, only very limited follow-up questions were asked, if any.

71. Nearly all nurse practitioner encounters involved less than five minutes of patient interaction, except in rare cases where the patient took longer to respond.

72. Although MedOptions' records typically indicate 10 minutes per encounter for "care coordination" with facility staff, Relator Saylor was only rarely directed to bring the videoconferencing equipment to facility staff so that the MedOptions nurse practitioner could speak with them. Relator Saylor is aware that the MedOptions nurse practitioner did not call or communicate with facility staff other than through the videoconference that Relator Saylor would arrange.

73. Furthermore, at the Beaver Dam facility, many patient records are maintained in paper copy. MedOptions' nurse practitioners would only rarely (every few months) direct Relator Saylor to check the current medications and dosages for the patients they were treating. Such basic information is obviously critical to the effective provision of medication management services, especially where psychotropic drugs have been prescribed. In the rare instances she was directed to obtain and provide this information, Relator Saylor was provided no secure means of electronic transmission and had no choice but to take pictures of the paper records on her cellphone and text them to the nurse practitioner.

74. Unsurprisingly then, the MedOptions' nurse practitioners rarely if ever made a proactive recommendation to alter a patient's medication. Such a recommendation was only made by MedOptions at the urging of facility staff.

75. Notwithstanding the perfunctory nature of MedOptions actual patient interaction and its infrequent "care coordination" with facility staff, MedOptions falsely documented in most instances that its patient visits lasted exactly 25 minutes.

76. For example, in Relators' review of 728 patient encounter records from August 2017 to February 2019 of patient visits that were purportedly performed by Lisamarie Pietragallo, 468 visits were recorded at exactly 25 minutes in length. Not a single visit was recorded at 24 minutes or 26 minutes.

77. An additional 246 visits by Ms. Pietragallo were recorded at exactly 10 minutes in length, and not a single visit was recorded at 9 minutes or 11 minutes. However, the patient encounter record for the majority of these visits indicated a billing code of 99214 – the second-highest intensity E/M code and one that is associated with a standard face-to-face duration of 25 minutes.

78. Together, 98% of these 728 visits were recorded as lasting exactly 25 minutes or 10 minutes.

79. Only 14 visits were recorded as involving any amount of time other than 25 or 10 minutes, and 13 of those 14 visits were recorded at exactly 15 or 45 minutes.

80. Similarly, in Relators' review of 194 patient encounter records of patient visits that were purportedly performed by Barbara Hignite, 152 visits were recorded at exactly 25 minutes, and not a single visit was recorded at 24 minutes or 26 minutes.

81. An additional 36 visits by Ms. Hignite were recorded at exactly 45 minutes in length, and not a single visit was recorded at 44 minutes or 46 minutes. Together, 97% of these 194 visits were recorded as lasting exactly 25 minutes or 45 minutes.

82. Recorded times of exactly 10, 25, or 45 minutes were likely chosen because Medicare billing requirements for certain services, such as psychotherapy and E/M visits that are primarily consultative, base the amount of reimbursement on the time spent providing patient care and have standard lengths of service at precisely these intervals.

83. That MedOptions never recorded spending any amount of time from 16-24 minutes or from 26-44 minutes in the more than 900 patient encounters of Ms. Pietragallo and Ms. Hignite is a clear indication that visit times were consciously selected to maximize reimbursement (by automatically claiming the standard length of time per visit to receive a given reimbursement amount) rather than to reflect the actual time spent delivering patient care.

C. Defendants Kept Patients Enrolled in Psychotherapy Treatment Longer Than Needed in Order to Increase Their Reimbursements From Government Healthcare Programs

84. Despite failing to provide the medical services that it was billing to Medicare, MedOptions' practice was to keep patients in psychotherapy treatment for as long as possible in order to maximize its total revenue regardless of medical necessity. This unlawful activity is well illustrated by Defendants' fraudulent use of "Acuity Scores."

85. In most cases, patients were only discharged after they or a family member complained about MedOptions' ineffectual services.

86. The patient encounter records created by MedOptions to record its psychotherapy services contained a section that discussed each patient's "Acuity Score." This was ostensibly to document the current degree of the patient's mental health condition as well as the "target" level that was sought.

87. In Relator Saylor's experience, MedOptions management directed that Facilitators such as herself perform basic tests of patients' condition in order to track their progress. Facilitators, however, do not have the professional qualifications or training to perform mental health evaluations.

88. The MedOptions psychologist that provided services to Beaver Dam patients during Relator Saylor's employment was Cynthia Geil. Mrs. Geil did not want unqualified Facilitators performing these tests on her patients and instructed them not to. As a result, these basic tests were not performed on her Beaver Dam patients and patients' "Acuity Scores" were not even discussed in the course of their treatment.

89. Notwithstanding that the basic tests to establish patients' Acuity Scores were not performed, a review of hundreds of patient records indicates that MedOptions nearly always recorded a present Acuity Score of 2 or 3 (on a scale of 0-5) and a target Acuity Score of 1, with an estimated time to target of 1-3 months. These false Acuity Scores, goals, and timetables acted to make additional "therapy" appear necessary and reasonable and thus perpetually justify additional treatment.

90. Tellingly, continued psychotherapy services by MedOptions did not improve the recorded Acuity Scores.

91. In Relators' review of 726 psychotherapy patient encounter records, not a single record ever indicated that a patient had reached their target acuity. Only five encounter records indicated that the patient had reached an acuity level of 1 (and those patients' target acuity was zero.) Thus, either the therapy was not working, or the scores were fictitious, or both.

92. MedOptions would only discharge patients upon the request of facility staff, the patient or their family, the transfer of a patient to hospice, or a patient's death. Otherwise, the treatment continued indefinitely.

93. In one instance, the daughter of a patient requested that her mother be discharged from MedOptions treatment after a MedOptions employee woke the patient up to ask if she was depressed.

94. The Beaver Dam MDS Coordinator recently asked Relator Cole why it was that all of the diagnoses recorded by MedOptions for their patients were for depression. Beaver Dam's in-house, experienced social worker also meets regularly with patients and records their mental health condition. For many MedOptions patients, the social worker did not record a diagnosis of depression.

95. In many instances, Relator Saylor observed that the MedOptions nurse practitioner would say that a patient looked "sad" and that therefore they must be depressed. It was unclear to Relator Saylor whether patients fully understood that these off-hand comments might reflect an actual clinical diagnosis of their mental health condition.

96. False diagnoses can result in unnecessary prescriptions and/or unnecessary or misdirected mental health therapy.

D. Defendants Created False Patient Records to Conceal Their Fraud

97. MedOptions created an Encounter Record for each patient visit that purports to document the critical aspects of each treatment. These records include the time spent providing the service, the date of service, the substance of the discussion with the patient, and the next steps in that patient's treatment.

98. Because MedOptions was not in fact providing the services that it documented and billed to Medicare, these patient records were materially false in numerous respects, including among others:

a. Time of Service: As explained above, MedOptions falsely records that telehealth visits last 10, 25, or 45 minutes in order to maximize billing revenue. In truth, these visits typically last only long enough for the remote practitioner to ask three questions of the patient.

b. Date of Service: MedOptions nurse practitioners would often schedule all patients at a particular facility on a single day but falsify patient records to indicate that some patients were seen on the following day. This was done so that the nurse practitioners could take days off work, and was enabled by the fact that they spent so little time on each patient.

c. Substance of Patient Interaction: Encounter records falsely state that a detailed psychological review was conducted in which certain specific mental health issues were discussed with the patient. Nurse practitioners would not ask many of the basic questions recorded in these records, such as inquiring as to Patient's various physiological systems, and the records indicated that the patients had "no complaints."

d. Care Coordination: MedOptions as a matter of practice recorded on patient records that the practitioner spent 10 minutes per session in "care coordination." Care coordination should entail discussion with facility staff and a patient's other healthcare providers to ensure that all are providing consistent treatment to the patient. Relator Saylor has personal knowledge that the nurse practitioners with

whom she worked only rarely spoke with facility staff about patients, and for very short periods of time (less than ten minutes) in the rare instances they did.

e. Billing Code: MedOptions' patient records sometimes listed one or more particular HCPCS codes that it attributed to specific encounters. These billing codes were false because MedOptions did not in fact provide the requisite time and substance of treatment for billing Medicare under those codes.

E. Defendants Failed to Use Secure Electronic Transmission to Protect the Confidentiality of Patient Health Information

99. Like all healthcare providers that transmit health information electronically, MedOptions is subject to federal regulations to ensure the security and confidentiality of their patients' personal health information. Among other requirements, MedOptions must take reasonable administrative, technological, and physical safeguards to protect and ensure the confidentiality of all personal health information they create, use, or transmit. *See* 45 C.F.R. § 164.306(a).

100. MedOptions does not have appropriate safeguards to protect the confidentiality of patients' personal health information, and in fact has instituted practices that put such information at risk of improper disclosure.

101. Relator Saylor was directed to use her personal cellphone (which was partially reimbursed) to take photographs of patient records, including diagnoses and medications, and to text or email them to the nurse practitioners. Relator Saylor did this for hundreds of patient encounters. She was told to delete these pictures afterwards and did so.

102. The ostensible reason that Relator Saylor was directed to use her personal cellphone to transmit patients' personal health information was because MedOptions did not

provide the technological equipment necessary to permit the secure, confidential transmission of this information.

103. However, it is precisely this type of secure, confidential transmission that CMS requires when healthcare providers use texting services to communicate patient information. "Texting of Patient Information among Healthcare Providers," CMS S&C 18-10-ALL (Dec. 28, 2017) ("In order to be compliant with the CoPs [Conditions of Participation] or CfCs [Conditions of Coverage], all providers must utilize and maintain systems/platforms that are secure, encrypted, and minimize the risks to patient privacy and confidentiality as per HIPAA regulations and the CoPs or CfCs. It is expected that providers/organizations will implement procedures/processes that routinely assess the security and integrity of the texting systems/platforms that are being utilized, in order to avoid negative outcomes that could compromise the care of patients.").

104. The contract between Beaver Dam and MedOptions specifies that Beaver Dam will provide a suitable internet connection but that MedOptions will provide the equipment needed to properly conduct treatment. Beaver Dam had reliable internet that MedOptions was able to use with its technology (in addition to fax machines). MedOptions never told Relator Cole as Administrator of Beaver Dam that it experienced problems with the facility's Wi-Fi or internet connectivity such that it could not properly perform under the contract.

105. At one point in time, MedOptions attempted to install equipment at Beaver Dam that would allow secure electronic transmission of patient information to its remote providers, but was not successful.

106. In the normal course of its operations, MedOptions would routinely compromise the security of patient health information by conducting telehealth sessions with patients while

nurse practitioners would have their husbands, children or grandchildren, or their housekeepers visible on the video screen.

107. MedOptions would conduct telemedicine visits with patients even when patients' roommates (or roommates' family) were present in the room and able to listen to their discussion of the patient's mental health condition.

108. Relator Saylor was never given any written policies on protecting the confidentiality of patient health information (or on any other topic), does not believe MedOptions has such policies, and was told that the company does not even have a Human Resources department.

109. Indeed, Relator Saylor was told by Randy DioGuardi, MedOptions' Executive Vice President of Operations, that he did not care if workers were under the influence of drugs or alcohol as long as they show up so the company can bill for patient visits.

F. Defendants Have Submitted False Claims to Medicare and Medicaid

110. Through the aforementioned conduct, MedOptions has submitted false claims to Medicare and Medicaid, including:

a. False claims for evaluation and management, and/or psychotherapy and medication management services that were not provided at all or were provided by non-qualified personnel.

b. False claims for evaluation and management, and/or psychotherapy and medication management services that were not provided for the required duration of time and thus overbilled.

c. False claims for evaluation and management, and/or psychotherapy and medication management services that were premised on falsified documentation, including that pertaining to Acuity Scores.

d. False claims for evaluation and management, and/or psychotherapy and medication management services that were conducted in violation of HIPAA.

VI. COUNTS

Count I
Federal False Claims Act
31 U.S.C. § 3729(a)(1)(A)

111. Relators re-allege and incorporate each allegation in each of the preceding paragraphs as if fully set forth herein and further allege as follows:

112. By virtue of the acts described above, Defendants "knowingly present[ed], or caus[ed] to be presented, false or fraudulent claims for payment or approval" in violation of 31 U.S.C. § 3729(a)(1)(A).

113. The United States, unaware of the foregoing circumstances and conduct, and in reliance on the truth and accuracy of the claims for payment, paid or authorized payment of those claims and has been damaged in an amount to be proven at trial.

Count II
Federal False Claims Act
31 U.S.C. § 3729(a)(1)(B)

114. Relators re-allege and incorporate each allegation in paragraphs 1 through 110 as if fully set forth herein and further allege as follows:

115. By virtue of the acts described above, Defendants have "knowingly ma[de], us[ed], or caus[ed] to be made or used, a false record or statement that was material to false or fraudulent claims" in violation of 31 U.S.C. § 3729(a)(1)(B).

116. The United States, unaware of the foregoing circumstances and conduct, and in reliance on the truth and accuracy of the claims for payment, paid or authorized payment of those claims and has been damaged in an amount to be proven at trial.

Count III
Federal False Claims Act
31 U.S.C. § 3729(a)(1)(G)

117. Relators re-allege and incorporate each allegation in paragraphs 1 through 110 as if fully set forth herein and further allege as follows:

118. By virtue of the acts described above, Defendants have "knowingly and improperly avoid[ed] or decreas[ed] an obligation to pay or transmit" money to the United States in violation of 31 U.S.C. § 3729(a)(1)(G).

PRAYER FOR RELIEF

WHEREFORE, Relators demand that judgment be entered in favor of the United States and against Defendants for the maximum amount of damages and such other relief as the Court may deem appropriate on each Count. This includes three times the amount of damages to the United States plus civil penalties of no more than $11,000 and no less than $5,500 for each false claim before or on November 2, 2015, and civil penalties of no more than $22,363 and no less than $11,181 for each violation after November 2, 2015, and any other recoveries or relief provided for under the FCA.

Further, Relators request that they receive the maximum amount permitted by law from the proceeds or settlement of this action as well as from any alternative remedies collected by the United States, plus reasonable expenses necessarily incurred, and reasonable attorneys' fees and costs. Relators request that their award be based upon the total value recovered, both tangible

and intangible, including any amounts received from individuals or entities who are not parties to this action.

DEMAND FOR JURY TRIAL

A jury trial is demanded in this case.

DATED: November 20, 2019

Respectfully submitted,

TACHAU MEEK PLC
David Tachau
Kristin E. McCall

PNC Tower, Suite 3600
101 S. Fifth Street
Louisville, KY 40202-3120
(502) 238-9900
dtachau@tachaulaw.com
kmccall@tachaulaw.com

COHEN MILSTEIN SELLERS & TOLL PLLC

Jeanne A. Markey (*pro hac vice* to be filed)
Gary L. Azorsky (*pro hac vice* to be filed)
Raymond M. Sarola (*pro hac vice* to be filed)
1717 Arch Street, Suite 3610
Philadelphia, PA 19103
Tel: (267) 479-5700
Fax: (267) 479-5701
jmarkey@cohenmilstein.com
gazorsky@cohenmilstein.com
rsarola@cohenmilstein.com

Sarah Hubbard (*pro hac vice* to be filed)
THE HUBBARD LAW FIRM, P.C.
330 E. 18th Street
Brooklyn, NY 11226
Tel: (917) 902-3606
Fax: (718) 233-4193
hubbard@hubbardpc.com

Counsel for Relators

CERTIFICATE OF SERVICE

I hereby certify that I will cause a copy of the above Complaint to be served on the following counsel by mail:

The Honorable William P. Barr
Attorney General of the United States
United States Department of Justice
950 Pennsylvania Avenue, N.W.
Washington, D.C. 20530-001

The Honorable Russell M. Coleman
United States Attorney
Western District of Kentucky
717 West Broadway
Louisville, KY 40202

DATED: November 20, 2019

Kristin McCall
Counsel for Relators