UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NEW YORK

[UNDER SEAL],	**FILED UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)**
Plaintiffs,	
v.	
[UNDER SEAL],	
Defendants.	

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA AND STATE OF NEW YORK, *ex rel.* CORTNEY HANSEN **v.** **CCS ONCOLOGY, P.C., COMPREHENSIVE CANCER SERVICES ONCOLOGY, P.C., Won Sam Yi, M.D., and Other Unknown Defendants Does 1-10,** **Defendants.**	**FILED UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)**

COMPLAINT

On behalf of the United States of America and the State of New York, Plaintiff and Relator Cortney Hansen files this *qui tam* Complaint against CCS Oncology, P.C. and Comprehensive Cancer Services Oncology, P.C. (collectively "CCS") and Dr. Won Sam Yi ("Dr. Yi") (collectively "Defendants"), and alleges as follows:

SUMMARY OF THE ALLEGATIONS

1. This is an action to recover treble damages and civil penalties on behalf of the United States of America and the State of New York in connection with a scheme perpetrated by CCS and Dr. Yi to maximize revenues from its oncology practices by knowingly and recklessly submitting false claims to federal and state health insurance programs for physician and treatment services that Defendants' know do not meet the Centers for Medicare and Medicaid Services' ("CMS's") billing conditions, in violation of the False Claims Act ("FCA") and the New York False Claims Act ("NYFCA").

2. CCS is a privately owned cancer treatment facility with locations throughout

Western New York which provides Comprehensive Cancer Services to patients with all stages and types of cancer, including radiation therapy, medical oncology, breast surgery, primary care, and head and neck surgery, among others.

3. From at least 2011 through the present, CCS and Dr. Yi have implemented a pervasive billing scheme throughout its treatment centers that has resulted in the submission of false claims to Medicare, Medicaid, and TriCare. Defendants routinely sacrifice patient safety in order to maximize profits, generating $29.6 million in revenues in 2013 alone. Since it has a patient population of approximately 40%-50% government insureds who were impacted by these practices, Defendants' scheme has necessarily caused substantial damage to the Government.

4. Defendants' schemes pervade nearly their entire oncology practice at CCS. For example, Defendants regularly submit claims for reimbursement of non-reimbursable or non-existent services, including false invoices for dangerous treatments performed by non-physicians in violation of CMS guidelines, and scores of medically unnecessary procedures and treatments.

5. Defendants also routinely upcode treatments to patients, billing the Government for more expensive procedures than are actually performed by submitted improper, higher billing codes, and engage in defacto upcoding by performing unnecessary, more expensive treatments solely for the purpose of receiving higher reimbursement from the Government.

6. Additionally, CCS bills the Government for numerous services it never actually performed, routinely churning invoices out to the Government without discretion.

7. Finally, CCS regularly provides kickbacks to patients in the form of waived co-pays without properly assessing financial hardship, using the waiver, instead, as an inducement for disgruntled patients frustrated by the excessive, and sometimes unnecessary, treatment regime imposed on them by CCS.

8. CCS's billing fraud shows a total disregard for its fragile, high risk patient population, performing procedures on patients who either do not need them, or are worse off because of them. Physicians' policies and treatment plans are guided by the ability to get the most out of CCS's billings, not what is in the best interest of the patient.

9. Relator has been a radiation therapy technologist at CCS since 2011, and has observed the fraudulent practices described herein from the time she started working at the company. Over the course of the last few years, Relator has raised several of these issues with other staff members, including CCS physicians, as well as CCS management. In the context of some of those discussions, it has been specifically communicated to Relator that the company's primary motive is to maximize revenues from private insurers and the government funded health insurance programs.

10. As a result of this scheme, CCS has defrauded the Government for at least $10-15 million in violation of the FCA and the NYFCA.

PARTIES

11. Relator Cortney Hansen is a New York resident and has been a certified radiation therapy technologist with CCS since 2011.

12. Defendant CCS is a privately owned New York professional corporation. CCS was named CCS Oncology, P.C. from June 30, 2008 until July 28, 2013. Since July 29, 2013, CCS has been known as Comprehensive Cancer Services Oncology, P.C.

13. Dr. Yi is a New York resident and a board certified physician oncologist. He is also the Medical Director and sole owner of CCS.

JURISDICTION AND VENUE

14. The Court has subject matter jurisdiction to entertain this action under 28 U.S.C.

§§ 1331 and 1345. The Court may exercise personal jurisdiction over the Defendants pursuant to 31 U.S.C. §§ 3732(a).

15. This Court has supplemental jurisdiction over the counts relating to the NYFCA pursuant to 28 U.S.C. §1367.

16. Venue is proper in the Western District of New York under 31 U.S.C. §§ 3732 and 28 U.S.C. §§ 1391(b) and (c) because the Defendants transact business in this District.

17. In accordance with 31 U.S.C. § 3730(b)(2), this Complaint has been filed *in camera* and will remain under seal for a period of at least 60 days and shall not be served on the Defendants until the Court so orders.

18. Pursuant to 31 U.S.C. § 3730(b)(2), the Relator must provide the Government with a copy of the Complaint and/or a written disclosure of substantially all material evidence and material information in their possession contemporaneous with the filing of the Complaint. Relator has complied with this provision by serving copies of this Complaint upon the Honorable William J. Hochul, Jr., United States Attorney for the Western District of New York, and upon the Honorable Eric H. Holder, Attorney General of the United States.

19. Relator is not aware that the allegations in this Complaint have been publicly disclosed. Further, to the extent Relator is aware of any public disclosures, this Complaint is not based on such public disclosures. In any event, this Court has jurisdiction under 31 U.S.C. § 3730(e)(4) because the Relator is an "original source" because she has provided her information voluntarily to the Government before filing this Complaint, and has knowledge which is both direct and independent of any public disclosures to the extent they may exist.

FEDERALLY FUNDED HEALTH INSURANCE PROGRAMS

A. Medicare

1) Medicare Background

20. Medicare is a federally-funded health insurance program for the elderly and persons with certain disabilities, providing both hospital insurance, Medicare Part A, which covers the cost of inpatient hospital services and post-hospital nursing facility care, and medical insurance, Medicare Part B, which covers the cost of the physician's services such as services to patients who are hospitalized, if the services are medically necessary and personally provided by the physician.

21. Medicare payments come from the Medicare Trust Fund, which is funded primarily by payroll deductions taken from the United States work force through mandatory Social Security deductions.

22. Medicare is generally administered by CMS, which is an agency of the Department of Health and Human Services. CMS establishes rules for the day-to-day administration of Medicare. CMS contracts with private companies to handle day-to-day administration of Medicare.

23. CMS, through contractors, maintains and distributes fee schedules for the payment of physician services. These schedules specify the amounts payable for defined types of medical services and procedures.

2) Reasonable and Necessary

24. Under Part A and Part B, Medicare will only pay for expenses 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). The Medicare Claims

Processing Manual further explains that "[i]f a service is not reasonable and necessary to treat illness or injury for any reason (including lack of safety and efficacy because it is an experimental procedure, etc.), carriers consider the service noncovered notwithstanding the presence of a payment amount for the service in the Medicare fee schedule." Medicare Claims Processing Manual, Chapter 23, § 30(A).

3) Diagnostic Testing

25. "A 'diagnostic test' includes all diagnostic x-ray tests, all diagnostic laboratory tests, and other diagnostic tests furnished to a beneficiary." Medicare Benefit Policy Manual, Chapter 15, § 80.6.1. Diagnostic tests must be performed with the required level of physician supervision in order to qualify as reasonable and necessary. 42 C.F.R. § 410.32(b). The diagnostic testing at issue in this case requires that the testing be directly supervised. "Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure." 42 C.F.R. § 410.32(b)(3)(ii); *accord* Medicare Benefit Policy Manual, Chapter 15, § 80. However, the physician is not required to "be present in the room when the procedure is performed." 42 C.F.R. § 410.32(b)(3)(ii).

4) CT Scans and Therapy

26. CT scans, are "[d]iagnostic examinations of the head (head scans) and of other parts of the body (body scans) performed by computerized tomography (CT) scanners." Medicare National Coverage Determinations Manual, § 220.1(A). Medicare will cover a CT scan "if medical and scientific literature and opinion support the effective use of a scan for the condition, and the scan is: (1) reasonable and necessary for the individual patient; and (2) performed on a model of CT equipment that meets" certain criteria. *Id.* Moreover, in order to be

eligible for payment, the scan must be "reasonable and necessary for the individual patient; i.e., the use must be found to be medically appropriate considering the patient's symptoms and preliminary diagnosis." Medicare National Coverage Determinations Manual, § 220.1(B). "Claims for CT scans are reviewed for evidence of abuse, which might include the absence of reasonable indications for the scans, an excessive number of scans, or unnecessarily expensive types of scans considering the facts in the particular cases." *Id.*

27. Procedures including "X-ray, radium, and radioactive isotope therapy, including materials and services of technicians" qualify as a "medical and other health service" under the Social Security Act. 42 U.S.C. § 1395x(s)(4). The Medicare Benefit Policy Manual provides that "X-ray, radium, and radioactive isotope therapy furnished in a nonprovider facility require direct personal supervision of a physician." Medicare Benefit Policy Manual, Chapter 15, § 90. While "[t]he physician need not be in the same room," the physician "must be in the area and immediately available to provide assistance and direction throughout the time the procedure is being performed." *Id.*

28. CPT Code 77014, "computed tomography guidance for placement of radiation therapy fields", "is used with CT-based systems (i.e. integrated cone beam CT, CT/linear accelerator on rails, helical tomotherapy)." American Society for Radiation Oncology (ASTRO), Imaging Guided Radiation Therapy (IGRT) Coding Guidance Article (January 2013), available at https://www.astro.org/Practice-Management/Radiation-Oncology-Coding/Coding-Guidance/Articles/Imaging-Guided-Radiation-Therapy-Coding-Guidance.aspx. "A radiation oncologist, or a medical physicist or trained therapist under the direct supervision of the radiation oncologist, reviews the automated image fusion and makes manual or automatic adjustments as necessary." *Id.* Medicare requires direct supervision for payment on this code. *Id.*

29. As of January 1, 2014, providers will no longer separately report code 77014 "when reporting simulation services represented by codes 77280-77290 and code 77295" because the "value of the professional and technical components of CT guidance is now captured within the simulation service." American Society for Radiation Oncology (ASTRO), Computed Tomography Guidance for Placement of Radiation Therapy Fields (77014) (March 2014), available at https://www.astro.org/Practice-Management/Radiation-Oncology-Coding/Coding-Guidance/Articles/Computed-tomography-guidance-for-placement-of-radiation-therapy-fields-(77014).aspx. Thus, "[a]t the time of simulation, CPT code 77014 may not be reported by the provider in either the freestanding or the hospital setting." *Id*. However, "CPT 77014 is also used to describe work associated with the IGRT process using a Cone Beam CT during the patient treatment session. That use of CPT 77014 remain[ed] valid for the year 2014." *Id*.

5) HDR Regulations

30. A high dose-rate remote afterloader is "a brachytherapy device that remotely delivers a dose rate in excess of 12 gray (1200 rads) per hour at the point or surface where the dose is prescribed." 10 C.F.R. § 35.2. The regulations provide that licensees shall require, for high dose-rate remote afterloader units:

> (i) An authorized user and an authorized medical physicist to be physically present during the initiation of all patient treatments involving the unit; and
>
> (ii) An authorized medical physicist and either an authorized user or a physician, under the supervision of an authorized user, who has been trained in the operation and emergency response for the unit, to be physically present during continuation of all patient treatments involving the unit.

10 C.F.R. § 35.615(f). The Nuclear Regulatory Commission ("NRC") has directed that the authorized medical physicist and either the authorized user or a physician are required to be physically present during the entire HDR brachytherapy treatment and that they must be within range of the normal and unamplified human voice. U.S. NRC Information Notice 2012-08, High Dose-Rate Remote Afterloader (HDR) Physical Presence Requirements (Apr. 10, 2012), available at http://pbadupws.nrc.gov/docs/ML1132/ML11320A228.pdf.

31. As provided in the regulations, an "authorized medical physicist" means an individual who:

> (1) Meets the requirements in §§ 35.51(a) and 35.59; or
>
> (2) Is identified as an authorized medical physicist or teletherapy physicist on --
>
> > (i) A specific medical use license issued by the Commission or Agreement State;
> >
> > (ii) A medical use permit issued by a Commission master material licensee;
> >
> > (iii) A permit issued by a Commission or Agreement State broad scope medical use licensee; or
> >
> > (iv) A permit issued by a Commission master material license broad scope medical use permittee.

10 C.F.R. § 35.2.

32. The regulations also provide that an "authorized user" means a physician dentist or podiatrist who:

> (1) Meets the requirements in §§ 35.59 and 35.190(a), 35.290(a), 35.390(a), 35.392(a), 35.394(a), 35.490(a), 35.590(a), or 35.690(a); or

> (2) Is identified as an authorized user on --
>
> > (i) A Commission or Agreement State license that authorizes the medical use of byproduct material;
> >
> > (ii) A permit issued by a Commission master material licensee that is authorized to permit the medical use of byproduct material;
> >
> > (iii) A permit issued by a Commission or Agreement State specific licensee of broad scope that is authorized to permit the medical use of byproduct material; or
> >
> > (iv) A permit issued by a Commission master material license broad scope permittee that is authorized to permit the medical use of byproduct material.

10 C.F.R. § 35.2.

33. Based on these requirements, the American Society for Radiation Oncology ("ASTRO") recommends that a clinic with 1 HDR brachytherapy unit that treats 50 patients per year should have staffing that includes 1 FTE medical physicist, 0.25 FTE medical dosimetrist, and 0.5 FTE dedicated brachytherapy technologist. Bruce R. Thomadsen, Ph.D et al, "A Review of Safety, Quality Management, and Practice Guidelines for High-Dose-Rate Brachytherapy," Practical Radiation Oncology, at 8-9 (2014).

6) <u>Co-Pay Waiver</u>

34. "Routine waiver of deductibles and copayments by charge-based providers, practitioners or suppliers 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."

Office of the Inspector General, "Special Fraud Alert," 59 Fed. Reg. 65372, 65374 (Dec. 19, 1994).

a. Co-Pay Waiver False Claims

35. Medicare pays charge-based providers and practitioners based on the "reasonable charge" for the service or item that is provided. 42 U.S.C. § 1395u(b)(3). Generally, Medicare pays 80 percent of the reasonable charge. 42 U.S.C. § 1395l(a)(1). Whether a charge is reasonable depends upon "(1) the actual charge for the item or service, (2) the customary charge for the item or service, (3) the prevailing charge in the same locality for similar items or services. The Medicare reasonable charge cannot exceed the actual charge for the item or service, and may generally not exceed the customary charge or the highest prevailing charge for the item or service." 59 Fed. Reg. 65374. When a provider or practitioner waives the Medicare copayment, it is misstating the actual charge. "For example, if a supplier claims that its charge for a piece of equipment is $100, but routinely waives the copayment, the actual charge is $80. Medicare should be paying 80 percent of $80 (or $64), rather than 80 percent of $100 (or $80). As a result of the supplier's misrepresentation, the Medicare program is paying $16 more than it should for this item." 59 Fed. Reg. 65375.

b. Co-Pay Waiver Kickbacks

36. The Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, renders it impermissible for anyone to solicit or receive kickbacks related to goods or services for which payment may be made, in whole or in part, pursuant to a Federal health care program.

37. The Anti-Kickback Statute defines "illegal remuneration" (*i.e.*, kickbacks) as:

> (1) whoever knowingly and willfully *solicits or receives* any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind –

> * * *
>
> (B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,
>
> * * *
>
> (2) whoever knowingly and willfully *offers or pays* any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person –
>
> * * *
>
> (B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

42 U.S.C. § 1320a-7b(b) (emphasis added). The offense is a felony punishable by fines of up to $25,000 and imprisonment for up to five years. 42 U.S.C. § 1320a-7b(b).

38. The Anti-Kickback Statute contains statutory exceptions and regulatory "safe harbors" excluding certain types of conduct from liability. *See* 42 U.S.C. § 1320a-7b(b)(3) and 42 C.F.R. § 1001.952. None of these statutory exceptions or regulatory safe harbors applies to Defendants' conduct in this matter.

39. The Medicare and Medicaid Patient and Program Protection Act of 1987 authorizes the exclusion of an individual or entity from participation in the Medicare and Medicaid programs if it is determined that the party has violated the Anti-Kickback Statute. In addition, the Balanced Budget Act of 1997 imposed administrative civil monetary penalties for Anti-Kickback Statute violations: $50,000 for each act and an assessment of not more than three times the amount of remuneration offered, paid, solicited or received, without regard to whether

a portion of such remuneration was offered, paid, solicited or received for a lawful purpose. *See* 42 U.S.C. § 1320a-7a(a)(7).

40. The Government has deemed such misconduct to be material to its decision to pay healthcare claims, in part through its requirement that providers certify compliance with this law as a condition of payment under, and participation in, Government healthcare programs. Providers and practitioners that waive Medicare copayments can be held liable under the Anti-Kickback Statute. "When providers, practitioners or suppliers forgive financial obligations for reasons other than genuine financial hardship of the particular patient, they may be unlawfully inducing that patient to purchase items or services from them." 59 Fed. Reg. 65375.

B. Medicaid

41. Medicaid is a state and federal assistance program to provide payment of medical expenses for low-income patients. Medicaid was created in 1965 in Title XIX of the Social Security Act.

42. Funding for Medicaid is shared between the federal government and state programs that choose to participate in Medicaid.

43. At all relevant times to the Complaint, applicable Medicaid regulations relating to coverage of claims by providers and physicians have been substantially similar in all material respects to the applicable Medicare provisions described above.

C. TRICARE

44. TRICARE is a federal program which provides civilian health benefits for military personnel, military retirees, and their families. TRICARE is administered by the Department of Defense and funded by the federal government.

45. At all relevant times to the Complaint, applicable TRICARE regulations relating to coverage of claims by providers and physicians have been substantially similar in all material respects to the applicable Medicare provisions described above.

46. Medicare, Medicaid, and TRICARE, and other similar federal programs are referred to collectively herein as "federal health insurance programs."

SPECIFIC ALLEGATIONS

A. CCS Oncology History and Background

47. In 2007, Dr. Yi purchased CCS. At the time, CCS had only one treatment facility and only a few employees. Since that time, under the entrepreneurial leadership of Dr. Yi, CCS has grown to five treatment centers (Williamsville, Niagara Falls, Windsong, Lockport, and Kenmore), as well as practices in colon-rectal & general surgery (Williamsville), general surgery (Amherst), primary care (Lockport and Cheektowaga), medical oncology (Williamsville, Dunkirk, Kenmore, and West Seneca), breast surgery (Williamsville), gynecologic oncology (Williamsville and Buffalo), genetic screening (Hamburg), and head and neck surgery (Williamsville). Currently, CCS employs more than 30 doctors and over 200 employees. CCS's six radiation oncologists rotate among the five treatment centers.

48. The rapid expansion of CCS is the result of a targeted strategy employed by Dr. Yi to create an automatic referral network by purchasing and absorbing other physicians' groups into CCS. By virtue of these acquisitions, Dr. Yi is able to access the patients of these other physicians generated by the nondiscretionary internal referrals. Despite the glaring conflict of interest, and potential Stark Law implications of these maneuvers, CCS, under Dr. Yi's guidance, continues to buy up other practices to increase its patient population and maximize its revenues.

49. Relator began working at CCS in 2011. At the time, CCS had just two treatment

centers and approximately twenty employees. Thus, she has personally witnessed the dramatic growth of the company over the last few years.

50. She has also personally observed the company's shifting priorities, migrating sharply from a patient care driven treatment facility to a profit driven enterprise. Over the course of this evolution, CCS's maximization of revenues has become the top priority for the company, causing a substandard level of care to patients, and ultimately, the submission of false claims to the Government as alleged herein.

B. CCS Aggressively Expands its Reach Throughout Western New York in order to Maximize Revenues and Recruit More Patients

51. CCS's dramatically expanding footprint in Western New York, and soaring revenues ($29.6 million in 2013 alone) are supported by high volumes of patients in its treatment centers and physician practice groups. Relator estimates that the treatment centers alone, open eight to nine hours per day, five days per week, provide treatments to approximately six patents per hour. This is in addition to the many consults and weekly follow up visits of patients currently under radiation treatment that physicians perform throughout the day.

52. In order to maintain the heavy volume of patients, CCS aggressively markets its business throughout the Central and Western New York regions. CCS advertises extensively through television and internet commercials as well as print advertisements in newspapers and magazines.

53. Many of these advertisements offer misleading messages designed to encourage patients to seek treatment at CCS. For example, CCS advertisements offer TrueBeam advanced radiotherapy system treatments, an innovative and highly effective cancer treatment, at all CCS locations, but in reality, CCS only offers TrueBeam treatments at its Windsong location. Relator

has personal knowledge that patients requesting TrueBeam at other locations are given other, less advanced treatments and advised that those treatments are just as effective as TrueBeam. Additionally, many of these patients are unaware of the fact that they are not being treated with TrueBeam. The purpose of these advertisements is to get patients in the door, regardless of the patient's motivation for seeking treatment there. Once at CCS, patients typically do not seek treatment at other oncology providers despite the disappointment of learning that the facility does not offer TrueBeam.

54. In addition, CCS regularly touts its ability to provide treatments that other facilities cannot, targeting patients who have been given a terminal diagnosis and offering false hope. CCS staff has been trained to manipulate these patients in order to take advantage of the revenues generated by their expensive treatments. Dr. Yi personally visits with many hospice assigned patients and often successfully convinces them that aggressive treatment, rather than end of life care, is in their best interest.

C. CCS Billed Medicare and Medicaid for Non-Reimbursable Services

55. During the course of her employment with CCS, Relator became personally aware that CCS routinely billed Medicare, Medicaid, and TriCare for non-reimbursable services under CMS guidelines in violation of the FCA and the NYFCA. Among the many non-reimbursable services provided and billed for by CCS are the following:

1. Radiation and Diagnostic Scans Performed Without the Presence or Direct Supervision of a Physician (Violates CMS Guidelines)

56. The administration of radiation therapy and certain other diagnostic services require specific presence or direct supervision by a properly certified, and authorized radiation oncologist.

57. Those services include High Dose Rate Radiation Therapy ("HDR") treatments, Imaging Guided Radiation Therapy ("IGRT"), livesource radiation treatments, certain treatment plan simulations and CT scans, as well as several other treatments performed at CCS facilities. HDR treatments in particular, delivering a high dose of radiation to a tumor quickly, require the direct supervision of a radiation oncologist. CMS guidelines provide that direct supervision means "immediately available to furnish assistance and direction throughout the performance of the procedure."

58. Relator has personal knowledge that CCS regularly disregards the supervision requirements for its services. For example, the Kenmore and Lockport treatment facilities begin treating patients at 7:00 a.m. and 8:00 a.m. respectively, Monday – Friday, but the physicians routinely do not arrive at those facilities until 7:30 a.m. or later. At these facilities, therefore, CCS is providing daily treatments and other radiation therapies, as well as diagnostic scans like IGRT, before a physician can be immediately present in compliance with CMS regulations.

59. In addition, several of the physicians, including most frequently Dr. Yi, see multiple patients at the same time, performing multiple consults and follow-up appointments while they should be immediately present for HDR and other radiation treatments and diagnostic scans such as IGRT. The consults and follow-up appointments are performed with other patients, behind closed doors, making it impossible to be immediately present for these overlapping treatments.

60. The following chart provides some examples of improperly performed, and billed, HDR treatments by CCS:

Doctor	Patient	Program	Date	Billing Issue
Yi	Patient A	Senior Blue	11/20/13	HDR performed at same time as 2 consultations and 2 follow-up appointments.
Yi	Patient A	Senior Blue	11/25/13	HDR performed at the same time as 1 consultation and 2 follow-up appointments.
Yi	Patient B	Medicare	10/27/14	AccuBoost performed at the same time as a consultation.
Yi	Patient C	Medicare	11/12/14	HDR performed at the same time as a consultation.
Yi	Patient D	Medicare	11/12/14	HDR performed at the same time as 1 consultation and 4 follow-up appointments.
Yi	Patient D	Medicare	11/24/14	HDR performed at the same time as 1 follow-up appointment and while Dr. Yi was out of the office at a meeting.
Yap	Patient E	Univera Senior Choice	1/6/15	HDR performed at the same time as 3 follow-up appointments.
Yap	Patient F	Medicare	1/6/15	HDR performed at the same time as 1 consultation and 1 follow-up appointment.
Yi	Patient G	IHA Enc 65	7/7/14	HDR performed at the same time as 3 consultations and 1 follow-up appointment.
Yi	Patient G	IHA Enc 65	6/30/14	HDR performed at the same time as 2 consultations and 1 follow-up appointment.
	Patient H	IHA Enc 65	5/29/12-6/7/12	8 treatments of AccuBoost without physician present throughout entire treatment.
	Patient I	Medicare	6/18/12-6/27/12	8 treatments of AccuBoost without physician present throughout entire treatment.
	Patient J	Medicare	7/2/12-7/12/12	8 treatments of AccuBoost without physician present throughout entire treatment.

	Patient K	Medicare	7/12/12-7/23/12	8 treatments of AccuBoost without physician present throughout entire treatment.
	Patient L	Univera Senior Choice	8/1/12-8/10/12	8 treatments of AccuBoost without physician present throughout entire treatment.
	Patient M	Fidelis	9/18/12-9/20/12	2 treatments of AccuBoost without physician present throughout entire treatment.

61. CCS has a busy practice, providing approximately six radiation treatments per hour. Thus, in the course of a year, CCS provides hundreds, if not thousands, of unsupervised treatments in violation of CMS guidelines. With only five full-time radiation oncologists for all five centers, many of which have consults and follow-ups throughout the day, CCS has created a situation that makes it impossible for these physicians to be present for all of the physician required treatments.

62. CCS's failure to provide supervisory care, in violation of CMS guidelines, renders the services non-reimbursable. While CCS keeps its overhead low, and its billings high, the Government reimburses CCS for millions of dollars in non-reimbursable claims and the patients are subjected to immense unnecessary risk.

63. CCS's violation of CMS guidelines, and subsequent billing of the Government for these non-reimbursable services, resulted in the submission of false claims in violation of the FCA and the NYFCA.

64. As a result of this fraud the United States and the State of New York have suffered substantial damages upon payment of these improper claims to CCS.

2. Complex Treatment Simulations on All Patients for All Treatments (Medically Unnecessary)

65. Radiation oncology treatment simulations are scans of treatment areas utilized to outline the location, and extent of a particular radiation treatment. The simulation defines the treatment fields, and a patient's skin is marked for treatment.

66. As described by CCS on its website:

> The simulation is the first step in planning for your actual radiation treatment. Using an x-ray machine called a "simulator," the therapist follows your doctor's instructions to "set up" your treatment. During the simulation, the therapist takes x-rays of the part of your body to be treated. These x-rays give the therapist a picture of the area to be treated and help to determine how the radiation will be directed to your body.

67. Simulations have different levels of intensity depending on the complexity of the cancer, the type of treatment, and the number of treatment sites – simple, intermediate, and complex.

68. Each simulation has its own corresponding CPT code with varying reimbursement rates. For example, in 2013, a complex simulation, billed under CPT code 77290 has a reimbursement rate of $1.181.57, while a simple simulation, billed under CPT code 77280 has a reimbursement of $601.81.

69. Relator has personal knowledge, however, that CCS universally performs complex simulations on all of its patients. Complex simulations on patients whose particular cancer or course of treatment warrant a less complex simulation are medically unnecessary. Under CMS guidelines, the provision of medically unnecessary services is not reimbursable by Medicare or Medicaid.

70. By providing complex simulations to every patient, prior to every treatment, CCS is causing the Government to pay at least several hundred dollars in unnecessary medical expenses per simulation.

71. CCS's submission of invoices for these non-reimbursable services violates the FCA and the NYFCA, causing substantial damages to the Government.

3. Respiratory Gating Scans on Patients Who Do Not Have Breathing Inhibiting Cancers (Medically Unnecessary)

72. In addition to the complex simulations, CCS performs numerous medically unnecessary respiratory gating scans on patients.

73. Respiratory gating scans are a type of CT scan used to measure the effect of a patient's breathing on a tumor site. Typically, gating scans are performed on patients with lung cancer, as well as other cancers near certain critical structures, such as the heart or the lungs. Importantly, gating scans allow radiation oncologists to adjust treatments based on the interaction between a patient's breathing and the placement of the patient's tumor.

74. CCS, however, routinely and inappropriately performs gating scans on patients with cancers that do not and could not be effected by their breathing. For example, Relator is personally aware of numerous cases in which CCS performed gating scans on patients with breast cancer in the right breast (arguably gating is appropriate for cancer in the left breast due to its proximity to the heart), liver cancer, gastrointestinal cancer, and stomach cancer.

75. Relator is informed and believes that none of the patients who received inappropriate gating scans subsequently received gating treatments, required for patient's whose tumors are effected by the patient's breathing.

76. The following table provides some examples of gating scans improperly performed on patients that are not reimbursable under CMS guidelines:

Doctor	Patient	Date	Location	Program	Gate Scan
Yi	Patient N	12/4/14	Lockport	IHA Enc 65	Liver
Yap	Patient O	11/13/14	Windsong	Senior Blue	Right Breast
Yap	Patient P	11/12/14	Windsong	Medicare	Bilateral Breasts
Yi	Patient Q	12/9/14	Kenmore	Senior Blue	Liver
Yi	Patient R		Windsong	Senior Blue	Right Breast
Yi	Patient S		Windsong	Senior Blue	Right Adrenal
Yi	Patient T		Windsong	Medicare	Right Breast
Yap	Patient U		Hamburg	Medicaid	Right Breast
Kossow	Patient V		Hamburg	Medicare	Right Breast
Yi	Patient W			United HC	Right Breast
Yi	Patient X	3/12/15	Lockport	Medicare- IHA Dual Difference	Abdomen /endometrial
	Patient Y	3/4/15		IHA Enc 65	Liver
	Patient Z	1/28/13		Medicaid	Abdomen
	Patient AA	1/21/13		Medicaid	Liver
	Patient AB	6/20/13		Medicare	Liver/Abdomen
	Patient AC	7/16/13		Medicare	Liver
	Patient AD	7/17/13		Medicare	Abdomen
	Patient AE	8/22/13		Medicare	Abdomen
	Patient AF	9/10/13		Medicare	Abdomen/Pancreatic duct

	Patient AG	9/25/13		Senior Blue	Liver
	Patient S	12/12/13		Senior Blue	Abdomen
Yap	Patient AH	3/19/14		Medicare	Abdomen
Yi	Patient AI	4/17/14		Medicare	Abdomen/right kidney
	Patient AJ	4/24/14		Medicare	Abdomen
Yap	Patient AK	8/7/14		IHA Medicare Enc B	Uterine
	Patient AL	5/18/14		Medicare	Abdomen/pelvis
Kossow	Patient AM	7/22/14		Excellus Blue PPO	Abdomen/Extrahepatic bile ducts
	Patient AN	8/6/14		Medicare	Abdomen/kidney
Yi	Patient AO	9/2/14		Medicare	Pancreas
Yi	Patient AP	2/3/15		IHA Enc 65	Right shoulder
	Patient S	1/15/15		Senior Blue	Right adrenal
Yi	Patient AQ	1/6/15	Windsong	Medicare Enc D	Pancreas

77. As with the simulations, the performance of medically unnecessary gating scans renders the services non-reimbursable under Medicare and Medicaid.

78. CCS's performance of these medically unnecessary respiratory gating scans on government insured patients resulted in the submission of false invoices to the Government for payment in violation of the FCA and the NYFCA.

4. Treatment on Solicited Patients Diagnosed with Terminal Cancers and Recommended for Hospice (Medically Unnecessary)

79. CCS, through its targeted marketing campaign, regularly recruits patients who have been turned away from other treatment facilities because further radiation treatment would either needlessly damage the patient's health or would just be ineffective.

80. Many of these patients have been given a terminal diagnosis and have been referred to hospice care. Dr. Yi and, under Dr. Yi's direction, other staff and physicians at CCS convince these patients that further treatment is not only appropriate, but could be effective in fighting their growing cancer. These inducements, in many cases, directly contradict the wishes and needs of the patients and a fatal diagnosis from other oncologists.

81. The treatments performed on these patients are not medically necessary under the CMS guidelines, and thus, non-reimbursable by Medicare or Medicaid.

82. Many of these patients, through false hope from Dr. Yi, continue with treatment until they succumb to the disease.

83. In order to prevent patients from going to hospice, Dr. Yi has instructed and trained CCS staff on effective ways to communicate with patients seeking to enter hospice in order to convince those patients to continue treatment. Dr. Yi's motivation is not based on a valid diagnosis that the patient's cancer is treatable, and that treatment is medically necessary, but to maximize CCS's revenues from private insurers and the government funded health insurance programs.

84. In one particular case, Patient BE, a 70 year-old patient receiving treatment for metastatic lung cancer and brain cancer, had been given a terminal diagnosis and was referred to hospice. Patient BE, exhausted from several rounds of treatment already and having come to terms with the terminal diagnosis agreed to be assigned to hospice. Reluctant to give up the revenue source, Dr. Yi convinced Patient BE to come back to CCS for more rounds of treatment. Patient BE died shortly after receiving the medically unnecessary round of treatment from CCS.

85. Relator is aware of other cases in which patients have received these medically unnecessary treatments from CCS in violation of CMS guidelines.

86. As a result of this fraudulent conduct, the Government has suffered substantial damages for the reimbursement of the false claims submitted to it by CCS.

5. Retreatment of Treatment Areas and Ignoring Dosing Limits (Medically Unnecessary)

87. Relator has personal knowledge that CCS dangerously retreats treatment areas well in excess of medically prescribed dosage limits in order to maximize revenue at exceptional risk to its patients.

88. The industry standard for prescribing radiation dosage limits is known as Quantitative Analyses of Normal Tissue Effects in the Clinic ("Quantec"). Quantec provides recommended dosage limits across a wide spectrum of cancers afflicting particular organs.

89. CCS physicians regularly ignore the Quantec guidelines, overtreating certain treatment areas and putting patients at severe risk of getting sick from overexposure to radiation and chemotherapy. Indeed, several patients have complained to CCS regarding the ill effects of overtreatment due to overexposure to radiation.

90. Relator has personally observed overtreatment of prostate cancer, metastatic bone cancer in the hip, rectal cancer, and brain cancer. In one case in particular, Relator observed Patient BF receive radiation three times in the same area of his spine.

91. Other medically unnecessary and dangerous retreatments performed by CCS include the following:

Doctor	Patient	Date	Program	Billing Issue
	Patient AR		Medicare	Pelvis Overtreatment
	Patient AS		Medicaid	Overtreatment
Yi	Patient AT	5/29/12	Medicare	Scalp treatment without a biopsy performed first; overtreatment to

				site, patient needed surgery and a skin graft by another physician within the practice.
Yi	Patient AU		Senior Blue	Overtreatment
Yi	Patient AV		Forever Blue	Overtreatment of left hip
Yap	Patient J		Medicare	Overtreatment of brain

92. CCS has put its already debilitated patients at greater risk by retreating them with radiation in order to maximize revenues. These retreatments are medically unnecessary, and thus are ineligible for reimbursement under CMS guidelines.

93. CCS's request for payment for these non-reimbursable services violates the FCA and the NYFCA.

6. Noncustomized Devices (No CPT Code Available)

94. Finally, Relator has personal knowledge that CCS routinely submits false claims to Medicare, Medicaid, and TriCare for the use of customized devices despite using non-customized devices for particular treatments.

95. For example, CCS regularly bills the Government for its use of a wingboard, a device used to immobilize certain treatment areas during treatment, under CPT code 77334. CPT code 77334, however, is reserved for standardized devices specifically designed for a particular patient. These devices, by definition, are not reusable for different patients during that course of therapy. Wingboards, on the other hand, are non-customizable and are regularly used interchangeably on patients during the course of their treatments.

96. In addition to falsely billing non-reimbursable, non-customizable devices as customized devices, CCS also maximizes revenues by billing the Government for treatment

devices it never actually uses. Specifically, CCS frequently bills the Government for the use of a vaclok, a device which positions and stabilizes a patient during treatment, for patients that do not need it, or even when the vaclok was not used. While a vaclok is a customizable, and thus reimbursable, treatment device, CCS regularly bills for its use without actually using it.

97. Some examples of CCS billing without actually using the vaclok include:

Doctor	Patient	Program	Date	Billing Issue
Yi	Patient AW	VA	11/26/14	Billed for vaclok that was not used.
Yi	Patient AX		11/24/14	Billed for vaclok that was not used.
Yi	Patient AY	VA	12/24/14	Charged for 77334 vaclok that was not used.
Yi	Patient AZ	VA	12/11/14	Charged for vaclok that was not used.
Yi	Patient AV	Forever Blue		Billed for vaclok that was not used.

98. Through the submission of claims to the Government for these non-reimbursable or nonexistent services, CCS has violated the FCA and the NYFCA.

D. CCS Fraudulently Billed Medicare and Medicaid for Services Not Rendered

99. CCS has also violated the FCA and the NYFCA by regularly submitting claims to the Government for reimbursement of several different types of services never rendered to patients. The services not rendered but fraudulently billed by CCS include:

1. Weekly Treatment Management Services

100. Medicare provides coverage for weekly treatment management under CPT code 77427 which requires a physician to provide treatment management once every five treatment sessions. Treatment management is not a minimal screening or passive service, but requires a visit with the patient and a full review of the patient's record. Thus, in order to properly bill the

Government under CPT code 77427, a physician must review of port films, review dosimetry, dose delivery, and treatment parameters, and examine the patient for medical evaluation and management (e.g., assessment of the patient's response to treatment, coordination of care and treatment, review of imaging and/or lab test results).

101. Relator has personal knowledge that CCS routinely bills the Government for weekly treatment management without providing the necessary review of the patient record. The billings under CPT Code 77427 are indiscriminately generated by the billing department, without any regard for whether or not the services are actually performed.

102. Accordingly, CCS knowingly submitted false claims to the Government for these weekly treatment management services without rendering any service. These false claims violate the FCA and the NYFCA, and damaged the Government.

2. IGRT Scans

103. Relator is also personally aware that CCS indiscriminately bills for IGRT scans it does not actually perform.

104. Each patient is provided, or not provided, an IGRT scan each day before treatment. The purpose of the scans, generally, is to determine whether the prescribed treatment volume is consistent with the patient's treatment plan simulation.

105. On several occasions, however, the IGRT scanner has failed, forcing treatment facilities to forgo the scan. On other occasions, facilities have become overwhelmed with patients that they had to skip the IGRT scan for certain patients in order to catch up.

106. Relator is personally aware that billing supervisors have instructed these facilities to bill for the IGRT scan anyway. As a matter of practice for at least the Kenmore and

Windsong facilities, CCS always bills for the IGRT scan, whether the scan has been performed or not.

107. For example, at Windsong, in one four-day span at the end of September 2014, the IGRT scanner was down. During that time, Windsong treated and billed for approximately 200 scans. Similarly, at Kenmore, the IGRT scanner has been down for extended periods of time but the CCS billing department, under the instruction of CCS management, continued to bill for the IGRT scans.

108. CCS also frequently performs IGRT scans on patients when a port film is more appropriate and necessary. In these cases, the IGRT scan is not reimbursable under Medicare, Medicaid, or TriCare. Some examples include:

Doctor	**Patient**	**Program**	**Area**	**Billing Issue**
Yap	Patient BA	Medicare	Left Elbow	CBCT daily should have been port film.
Shanbhag	Patient BB	VA	Left Elbow and Right Knee	CBCT daily should have been port film.
Yi	Patient BC	VA	Whole Brain	CBCT daily should have been port film.
Shanbhag	Patient AZ	VA	Left Hip and Right Hip	CBCT daily should have been port film.

109. CCS's billing for services not rendered or for services that are medically unnecessary are direct violations of the FCA and NYFCA, causing substantial damages to the United States and the State of New York.

3. Upcoded Electron and Photon Beam Therapy Treatments

110. CCS also treats patients with electron and photon beam therapy treatment, treatments which apply electrons or photons directly to a tumor site. These treatments are

generally used on superficial tumors for certain cancers, including lymphoma and melanoma among others, and are usually given four times a week over a three to four week span. There are different intensities of electron and photon beam treatment and thus different corresponding CPT codes.

111. Relator has personally observed that CCS regularly upcodes these treatments, billing under the higher CPT code despite providing the lower energy treatment. Some examples include:

Doctor	**Patient**	**Program**	**Billing issue**
Yap	Patient BD	Fidelis	Billed CPT 77414 instead of CPT 77413 for 6 photon treatments.
Yi	Patient BC	VA	Billed CPT 77414 instead of CPT 77413 for 6 photon treatments.

112. CCS is thus billing for a higher intensity, more expensive treatment that it is not actually providing to the patients.

113. The upcoding of these treatments results in the billing of services not rendered in violation of CMS guidelines and results in false claims to the Government.

4. CCS Falsifies Medical Records to Unbundle CPT Codes

114. CMS guidelines require that certain treatments and procedures be performed and billed on separate days. If, however, these treatments are performed on the same day, they must be bundled under a single CPT Code.

115. For example, CPT code 77301 should be used for IMRT treatment planning, which incorporates several other CPT codes which form the building blocks during the development of IMRT planning. Accordingly, CPT codes 77014, 76376, 77295, 77331, 77280, 77285, 77290, 77305, 77310, and 77315, among others, should all be billed as 77301 performed on the same day as IMRT planning.

116. Relator has personal knowledge that CCS routinely unbundles these services, generally comprised of scans, simulations, and dosimetry procedures, and bills them individually rather than under the 77301 treatment code. In order to do this, and avoid detection by CMS, physicians and CCS medical staff back-date the unbundled procedures so that they appear to be performed on different days.

117. The unbundling of the individual procedures significantly increases the amount of funds reimbursed to CCS for these treatments.

118. The falsification of medical records by CCS physicians results in the submission of false invoices to the Government in violation of the FCA and the NYFCA.

E. CCS Provided Kickbacks in the Form of Waived Copayments in Violation of the Anti-kickback Statute and False Claims Act

119. CCS routinely waives patient co-pays, which causes the submission of false claims in violation of the FCA and results in violations of the anti-kickback statute.

120. Medicare typically pays 80 percent of the reasonable charge of the treatment provided. 42 U.S.C. § 1395l(a)(1). The patient pays the remaining 20 percent, known as the co-pay.

121. CCS administers simulations and treatments to patients at an extremely high frequency. As a result, CCS's patients are required to pay a substantial number of co-pays at significant cost.

122. Relator is aware that patients complain to CCS regarding the frequency and cost of the co-pays, and that as a result of patient complaints, CCS routinely waives or reduces the co-pays that patients must pay for treatments. CCS offers the waiver as an inducement to keep the

patients coming back for their excessive, and often medically unnecessary treatments, rather than assessing the patient's individual financial need.

123. CCS does not report the waiver or reduction of the co-pay to Medicare when seeking payment. Thus, CCS is misstating the actual charge of the service, and causing a false claim to be submitted for reimbursement. 59 Fed. Reg. 65375.

124. Additionally, CCS's waiver of patient co-pays results in violations of the anti-kickback statute because it is "unlawfully inducing . . . patient[s] to purchase items or services from them." 59 Fed. Reg. 65375. Had CCS not waived or reduced the co-pay, patients would not have sought the treatment.

F. The FCA Violations Committed by Defendants Imposed Substantial Damages on the United States and the State of New York

125. As alleged herein, Defendants pervasive violations of CMS guidelines have directly resulted in the submission of false claims to the United States and the State of New York.

126. Relator has personal knowledge that the scheme has been operating from at least January 2011 when she began working at CCS, and is informed and believes that Dr. Yi and CCS had been defrauding the Government well before then.

127. Based on the percentage of the patients belonging to government funded health insurance programs, and the cost of the treatments being fraudulently reimbursed by the Government due to Defendants' fraud, Relator is informed and believes that Defendants' submission of false claims to the Government has totaled at least $10-$15 million.

COUNT I
SCHEME TO SUBMIT FRAUDULENT CLAIMS
(31 U.S.C. § 3729(a)(1)(A))

128. All of the preceding allegations are incorporated herein.

129. As more particularly set forth in the foregoing paragraphs, by virtue of the acts alleged herein, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment or approval in violation of 31 U.S.C. § 3729(a)(1)(A).

130. As a result of Defendants' acts, the United States has been damaged, and continues to be damages, in a substantial amount to be determined at trial, and the United States is entitled to at least $5,000 and up to $11,000 for each and every violation of 31 U.S.C. § 3729 arising from Defendants' unlawful conduct as described herein.

COUNT II
SUBMISSION OF CLAIMS CONTAINING
FALSE EXPRESS CERTIFICATIONS
(31 U.S.C. § 3729(a)(1)(A))

131. All of the preceding allegations are incorporated herein.

132. As more particularly set forth in the foregoing paragraphs, by virtue of the acts alleged herein, the Defendants have knowingly made, used, or caused to be made or used, false records or statements – i.e., the false certifications and representations made or caused to be made by defendant – material to false or fraudulent claims in violation of 31 U.S.C. § 3729(a)(1)(B).

133. As a result of Defendants' acts, the United States has been damaged, and continues to be damaged, in a substantial amount to be determined at trial, and the United States is entitled to at least $5,000 and up to $11,000 for each and every violation of 31 U.S.C. § 3729 arising from Defendants' unlawful conduct as described herein.

COUNT III
FALSE RECORDS FOR PAYMENT
(31 U.S.C. § 3729(a)(1)(B))

134. All of the preceding allegations are incorporated herein.

135. Defendants submitted false records or statements to the Government representing that Defendants were entitled to payment and approval for health care services provided to beneficiaries of federal health insurance programs.

136. All such false records or statements were knowingly made to the Government to get false or fraudulent claims paid or approved by the Government.

137. Defendant thus knowingly made, used, or caused to be made or used, false records or statements to get false or fraudulent claims paid or approved by the Government.

138. As a result of Defendants' acts, the United States has been damaged, and continues to be damages, in a substantial amount to be determined at trial, and the United States is entitled to at least $5,000 and up to $11,000 for each and every violation of 31 U.S.C. § 3729 arising from Defendants' unlawful conduct as described herein.

COUNT IV
FALSE CLAIMS CONSPIRACY
(31 U.S.C. § 3729(a)(1)(C))

139. All of the preceding allegations are incorporated herein.

140. Defendants entered into a conspiracy or conspiracies through their member physicians, officers, and employees to defraud the United States by submitting and obtaining approval and payment for false and fraudulent claims for health care services provided to beneficiaries of federal health insurance programs.

141. Defendants also conspired through their member physicians, officers, and employees to omit disclosing or to actively conceal facts which, if known, would have reduced

the federal government's obligations to pay them or would have required them to repay the federal government.

142. As a result of Defendants' acts, the United States has been damaged, and continues to be damages, in a substantial amount to be determined at trial, and the United States is entitled to at least $5,000 and up to $11,000 for each and every violation of 31 U.S.C. § 3729 arising from Defendants' unlawful conduct as described herein.

COUNT V
FALSE RECORDS TO AVOID REFUND (31 U.S.C. § 3729(a)(1)(G))

143. All of the preceding allegations are incorporated herein.

144. By virtue of the acts alleged herein the Defendants knowingly made, used or caused to be made or used false records or false statements that are material to an obligation to pay or transmit money to the Government.

145. As a result of Defendants' acts, the United States has been damaged, and continues to be damages, in a substantial amount to be determined at trial, and the United States is entitled to at least $5,000 and up to $11,000 for each and every violation of 31 U.S.C. § 3729 arising from Defendants' unlawful conduct as described herein.

COUNT VI
New York False Claims Act,
N.Y. Fin. Law §§ 187, et seq.: Presentation of False Claims

146. Relator repeats and incorporates by reference the allegations above as if fully contained herein.

147. As more particularly set forth in the foregoing paragraphs, Defendants "knowingly present[ed], or cause[d] to be presented, to any employee, officer or agent of the state or a local government, a false or fraudulent claim for payment or approval," in violation of

N.Y. Fin. Law § 189.1(a).

148. Unaware of the falsity of claims presented or caused to be presented, the New York state government has paid and continues to pay the claims that would not have been paid but for the fraudulent acts and conduct of Defendants.

149. By reason of Defendants' fraudulent acts, the State of New York has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

COUNT VII
New York False Claims Act,
N.Y. Fin. Law §§ 187, et seq.: Making or Using A False Record or Statement to Cause Claim to be Paid

150. Relator repeats and incorporates by reference the allegations above as if fully contained herein.

151. Defendants "knowingly ma[de], use[d], or cause[d] to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state or local government," in violation of N.Y. Fin. Law § 189.1(b).

152. Unaware of the falsity of records or statements knowingly made, used, or caused to be made or used by Defendants, the New York state government has paid and continues to pay the claims that would not have been paid but for the acts and conduct of Defendants.

153. By reason of Defendants' acts, the State of New York has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

PRAYER FOR RELIEF

WHEREFORE, for each of these claims, the Qui Tam Plaintiff requests the following relief from each of the Defendants, jointly and severally, as to the federal claims:

1. Three times the amount of damages that the Government sustains because of the acts of Defendants;

2. A civil penalty of $11,000 for each violation;

3. An award to the Qui Tam Plaintiff for collecting the civil penalties and damages;

4. Award of an amount for reasonable expenses necessarily incurred;

5. Award of the Qui Tam Plaintiff's reasonable attorneys' fees and costs;

6. Interest;

7. Such relief as is appropriate under the provisions of 31 U.S.C. § 3730(h) of the False Claims Act for retaliatory discharge, including: (1) two times the amount of back pay with appropriate interest; (2) compensation for special damages sustained by Relator in an amount to be determined at trial; (3) litigation costs and reasonable attorneys' fees; (4) such punitive damages as may be awarded under applicable law; and (5) reasonable attorneys' fees and litigation costs in connection with Relator's Section (h) claim;

8. Such further relief as the Court deems just; and

WHEREFORE, for each of these claims, the Qui Tam Plaintiff requests the following relief from each of the Defendants, jointly and severally, as to the New York claims:

1. Relator and the State Plaintiff be awarded statutory damages in an amount equal to three times the amount of actual damages sustained by New York as a result of Defendants' actions, as well as the maximum statutory civil penalty for each violation by Defendants within New York, as provided by N.Y. Fin. Law § 189.1(g);

2. Relator be awarded her Relator's share of any judgment to the maximum amount provided pursuant to N.Y. Fin. Law § 190.6;

3. Relator be awarded all costs and expenses associated with each of the pendent State claims, plus attorneys' fees as provided pursuant to N.Y. Fin. Law § 190.7; and

4. Relator and the Plaintiffs be awarded such other and further relief as the Court may deem to be just and proper.

JURY DEMAND

Relator hereby demands trial by jury.

Dated: April 3, 2015

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