FOR THE SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

UNITED STATES OF AMERICA, *ex rel.* Chionesu Sonyika, Relator,	§	
STATE OF FLORIDA, *ex rel.* Chionesu Sonyika, Relator,	§	
STATE OF GEORGIA, *ex rel.* Chionesu Sonyika, Relator,	§	
STATE OF INDIANA, *ex rel.* Chionesu Sonyika, Relator,	§	
STATE OF IOWA, *ex rel.* Chionesu Sonyika, Relator,	§	**Civil Action No. 17-CV-20012-KMW**
STATE OF TENNESSEE, *ex rel.* Chionesu Sonyika, Relator,	§	**COMPLAINT FOR DAMAGES UNDER THE FEDERAL FALSE CLAIMS ACT AND VARIOUS STATE FALSE CLAIMS ACTS AND DEMAND FOR JURY TRIAL**
STATE OF TEXAS, *ex rel.* Chionesu Sonyika, Relator,	§	
Plaintiffs,	§	
v.	§	
ApolloMD, Inc., Independent Physicians Resource, Inc., ApolloMD Business Services, LLC, Apollo MD Holdings, LLC, PaymentsMD, LLC, ApolloMD Group Services, LLC, ApolloMD Physician Partners, Inc., ApolloMD Physician Services FL, LLC, and Georgia Emergency Group, LLC,	§	
Defendants.	§	

PLAINTIFFS' FIRST AMENDED COMPLAINT

Relator CHIONESU SONYIKA, M.D., ("Relator" or "Dr. Sonyika") in the above-styled action brings this suit on behalf of the United States of America (the "United States") and the States of Florida, Georgia, Indiana, Iowa, Tennessee and Texas (collectively the "Plaintiff States") against Defendants ApolloMD, Inc., Independent Physicians Resource, Inc., ApolloMD Business Services, LLC, ApolloMD Holdings, LLC, PaymentsMD, LLC, ApolloMD Group Services, LLC, ApolloMD Physician Partners, Inc., ApolloMD Physician Services FL, LLC, Georgia Emergency Group, LLC, and their related parents, affiliates, subsidiaries, successors and predecessors (collectively "Defendants" or "Apollo").

I. INTRODUCTION

1. Apollo is a privately-held, national group practice that provides staffing and management services to hospitals related to emergency medicine, hospital medicine, anesthesia and radiology. Headquartered in Atlanta, Georgia, Apollo has a presence (or has had a presence during the relevant time period) at hospitals and healthcare centers in at least sixteen (16) states, including in the Plaintiff States. Apollo's revenue in 2014 totaled over $400 million. This case is about Apollo's use of a fraudulent scheme (the "Scheme") to systematically submit false claims to the Centers for Medicare and Medicaid Services ("CMS") and Plaintiff State's Medicaid programs for reimbursement for services performed by "mid-level" healthcare providers (e.g., physician assistants and nurse practitioners) at Apollo emergency rooms. Apollo knowingly and intentionally carries out its unlawful national Scheme to obtain grossly overpaid reimbursement amounts from CMS and Plaintiff State's Medicaid program.

2. Relators bring this action pursuant to the *qui tam* provisions of the Federal False Claims Act, 31 U.S.C. § 3729 *et. seq*. ("FCA"), and the similar *qui tam* provisions of the Florida

False Claims Act, Fl. Stat. §§ 68.081 *et. seq.*; Georgia False Medicaid Claims Act, Ga. Code Ann. §§ 49-4-168 *et. seq.*; Indiana Medicaid False Claims and Whistleblower Protection Act, Ind. Code §§ 5-11-5.7-1 *et. seq.*; Iowa False Claims Act, IOWA CODE §§685.1 *et seq.*; Tennessee Medicaid False Claims Act, Tenn. Code §§ 71-5-181 *et. seq.*; and the Texas Medicaid Fraud Prevention Act, Tex. Hum. Res. Code §§ 36.002 *et. seq.*

3. Under the Scheme, Apollo uniformly and systematically overbills CMS and the Plaintiff States for services performed solely by physician assistants ("PAs") and nurse practitioners ("NPs")—collectively "mid-levels" or "advanced practice clinicians" ("APCs")—by submitting claims for these mid-level services under a physician's National Provider Identification number ("NPI") as if a physician, rather than a mid-level, had performed the services, thus triggering the full physician rate for reimbursement. When a mid-level performs services alone, without any physician involvement, CMS only reimburses for those services at 85% of the physician rate. *See* 42 U.S.C. § 1395l(a)(1)(O). The overwhelming majority of services provided by mid-levels in Apollo emergency departments are carried out with *no physician involvement.* Accordingly, under CMS regulations, these services should be billed under the mid-level's NPI and reimbursed at 85% of the physician's rate. Yet, Apollo submits every claim for mid-level services under a physician's NPI, which automatically triggers the physician's reimbursement rate. In other words, Apollo is systematically and unlawfully requesting reimbursement for mid-level services at 100% of the physician rate, rather than the proper 85% rate, thereby reaping a 15 percentage-point premium for every mid-level service performed in its emergency departments.

4. Similarly, the Plaintiff States' respective Medicaid programs reimburse for mid-level services at lower rates than for physician services. However, because Apollo submits

claims for mid-level services under physicians' NPIs, Apollo unlawfully requests reimbursement from the Plaintiff States for mid-level services at 100% of the physician rate, rather than the appropriate mid-level percentage paid by each Plaintiffs State's respective Medicaid programs.

5. Apollo's own chief executives have admitted the national uniformity of Apollo's fraudulent billing practices for mid-level services. On December 2, 2016, Apollo's Chief Operating Officer, Amy Katnik, sent to all Apollo emergency physicians a nationwide email on behalf of and written by Apollo's Chief Quality Officer, Michael Liscomb, explicitly stating that, for Medicare patients, *all* mid-level charts are "billed under the physician NPI number"—*i.e.* regardless of whether the physician actually saw the patient. *See* Exhibit 1 (discussed more fully in ¶¶ 49-56). Because the NPI number is what automatically triggers the reimbursement rate, this fact, which Apollo itself has confirmed, is an admission of fraud and establishes the existence and the national breadth of Apollo's unlawful Scheme. This email, which is attached hereto as Exhibit 1, is more than reliable indicia of fraud; and it is more than direct, internal evidence of the fraudulent Scheme at issue in this case. It is an admission of liability. There is simply no way under the Medicare and Medicaid systems at issue to submit claims for reimbursement for mid-level services under a physician NPI in a manner that is *not* fraudulent. Apollo cannot have a reasonable excuse or explanation for this practice. Moreover, as alleged herein, Apollo does it knowingly and intentionally *because* it makes Apollo more money (which Apollo then shares with its physicians in the form of kickbacks).

6. Apollo attempts to cover up its Scheme by manipulating charts to falsely reflect what is referred to in the Medicaid regulations as a "split/shared visit." A split/shared visit occurs when a mid-level *and* a supervising physician both treat the same patient, meaning that both the physician and the mid-level actually provide face-to-face services to the patient. When a

true split/shared visit occurs, CMS reimburses for the mid-level services at the same rate as the physician's services, as if the mid-level were an extension of the physician. In the emergency department, a properly documented split/shared visit is the only circumstance under which mid-level services may be reimbursed at the full physician rate.

7. However, true split/shared visits are exceedingly rare in Apollo's emergency departments. Physicians and mid-levels rarely, if ever, see patients together. Instead, to maximize efficiency and avoid overlap under Apollo's business model, mid-levels independently treat lower-acuity patients and physicians independently treat higher-acuity patients. Relator personally performed true split/shared visits in less than 1% of the emergency patients he treated at Apollo. This was customary for all physicians Relator worked with.

8. Notwithstanding this reality, Apollo requires[1] physicians and mid-levels to indicate in *every* mid-level medical chart that the physician provided the services to the patient by demanding that physicians sign *every* mid-level chart and indicate that the physician also treated the patient seen by the mid-level so that Apollo can bill for the mid-level services under the physician's NPI at the full physician rate. For example, in the following March 14, 2013 email to numerous healthcare providers, Apollo Credentialing Specialist Liz Hawkins instructed Apollo physicians to sign all of the mid-level charts assigned to them—*i.e.*, regardless of whether the physicians had face-to-face encounters with the mid-level patients.

[1] As used throughout this Complaint whenever referencing what Apollo "requires," the term "require" means that Apollo has made the issue concerned a protocol, business practice, policy, procedure, matter of training and/or something that can be, and is, used to threaten employment if there is no compliance.

From: **Liz Hawkins** lhawkins@apollomd.com
Subject: Deficient charts with Dr. Signature
Date: March 14, 2013 at 8:06 AM
To: balimd7@yahoo.com, brett.cannon@gmail.com, drsonyika@yahoo.com, gfilmore@gmail.com, gmwilliams76@gmail.com, jwwalraven@bellsouth.net, jimsonsmith2@gmail.com, anniev@hotmail.com, KIMBERLY HALL takdoves@bellsouth.net, nnkwuo@yahoo.com, tonepolk@yahoo.com, richisa@aol.com, Wazeerud-Din MD (wazeeds@hotmail.com) wazeeds@hotmail.com, T. Howard thelhoward@yahoo.com, Christina.K.Eid Christina.K.Eid@live.mercer.edu, christina.guice@yahoo.com, Darron Deal darron.deal@gmail.com, l.nichole@yahoo.com, Lyndsey Taylor lyndseymtay@gmail.com, Michael Clark michael.andrew.clark@gmail.com, reenataank@gmail.com, sarah.jeanne.clark@gmail.com sarah.jeanne.clark@gmail.com, mcsassy98@yahoo.com, sheatab@comcast.net, tikilake@gmail.com
Cc: diondavid.sfmc@gmail.com, Jody Camp jcamp@apollomd.com

LH

I'm receiving **numerous** deficient charts from coding with **Dr. Signature deficiency** which Is Physician signature and the midlevel attestation missing on the charts. **Midlevels** please be sure you make sure the Physician assigned to the patient has their signature & attestation completed. **Physicians** please make sure you go through the midlevel charts and attest with your signature that you reviewed the charting etc.

Thank you,

Liz Hawkins
Credentialing Specialist
ApolloMD
5665 New Northside Drive, Suite 320
Atlanta, Georgia 30328
Office: 404-645-7840
Fax: 678-235-6758

lhawkins@apollomd.com

ApolloMD™
Emergency Medicine • Anesthesia • Radiology • Hospital Medicine

Apollo requires this even when, as is overwhelmingly the case, no split/shared visit occurred. Once Apollo has the physician-signed mid-level charts in hand, the charts are "billed under the physician NPI number," as Apollo's COO admits. *See* Exhibit 1. **This is a clear violation of CMS requirements—and, therefore, fraud**. CMS, MEDICARE CLAIMS PROCESSING MANUAL, pub 100-04, Ch. 12, § 30.6.1(B) ("[I]f there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the [mid-level's NPI]").

9. An important facet of Apollo's fraud can be seen in the following December 4, 2012 email from Adrian Dawson, ApolloMD Group Coordinator (at Spalding Regional Medical Center). Therein, Dawson instructs Apollo mid-levels to assign *all* of their charts to physicians

for signing. Dawson also instructs physicians to sign[2] *all* such charts assigned to them and states that failure to do so "negatively affects reimbursement and in turn, our paychecks."

From: **Dawson, Adrian** ADRIAN.DAWSON@tenethealth.com
Subject: signatures
Date: December 4, 2012 at 5:24 PM
To: Alice Fray amfray@aol.com, Camille Miller cam79miller@gmail.com, Chionesu Sonyika drsonyika@yahoo.com, Denis Kim denisjkim@yahoo.com, Fun Fong fun.fong.jr@gmail.com, Jennifer Host jhostmd@gmail.com, Lynn Flowers lflowers@apollomd.com, Marlon Fisher mfisher6@hotmail.com, Mike Webb mwebbkay@aol.com, Raul Rodon rrodon@apollomd.com, Richisa Johnson-Hamilton richisa@aol.com, Robert Cox rjcox01@aol.com, Robert Hull rhullmd@yahoo.com, Shannon Howell showell727@yahoo.com, Swetang Desai spd4977@yahoo.com, Theltonia Howard thelhoward@yahoo.com, Tony Polk tonepolk@yahoo.com, Wesley Leigh wesleyleigh@aol.com, Chris Pitts chrispittspac@hotmail.com, Dawn Adams daadams66@comcast.net, Kacie Jones kacieleigh1@aol.com, Leimbach, Jennifer jennifer.leimbach@lmunet.edu, Pohl, Melanie unvmel12@hotmail.com, Pryor, Anita anitapryor@att.net, Scott Anderson seapac65@yahoo.com, Short, Dennis shrtdnns@aol.com, Stephanie Jackson stephanieb.jackson@yahoo.com, Tonya Ogletree tonyaogletree@gmail.com, Young, Daniel1 danyoungpac@gmail.com

Good evening, everyone. Please remember to SIGN (or for the midlevels, assign) all of your charts. One of the biggest issues I see on my deficient list is that the charts are not signed. Apparently, it is not enough that you "perform" "modify" or "verify" a chart, it must also be signed in order to push through. We currently have well over 500 deficient charts for the month of November, and yesterday was the deadline to have them all completed for coding. If I give you a list of deficient charts, please do your best to complete it that day. I know the new system makes this difficult, but this is a significant delay in coding that very negatively affects reimbursement and in turn, our paychecks. If you have technical questions, please contact the help desk at extension 5965.

Thank you,
Adrian Dawson
ApolloMD Group Coordinator
Spalding Regional Hospital
601 S. 8th St
Griffin, GA 30224
phone 770-228-2721, x2150
fax 770-467-6138
adrian.dawson@tenethealth.com

Similarly, the following December 5, 2012 email from Dawson to numerous Apollo providers shows the automated system that Apollo set up to carry out the Scheme with ease. Under this system, Apollo (1) requires its mid-levels to arbitrarily assign their charts to on-duty physicians, and then (2) requires those physicians to sign the mid-level charts despite never having treated the mid-level's patients.

[2] To "sign" mid-level's charts as Apollo required, physicians like Relator simply had to click the "sign" button within the EMR (electronic medical record) software. Clicking such button functioned to place the physician's signature on all mid-level charts assigned to the physician.

From: **Dawson, Adrian** ADRIAN.DAWSON@tenethealth.com
Subject: FirstNet
Date: December 5, 2012 at 3:38 PM
To: Alice Fray amfray@aol.com, Camille Miller cam79miller@gmail.com, Chionesu Sonyika drsonyika@yahoo.com, Denis Kim denisjkim@yahoo.com, Fun Fong fun.fong.jr@gmail.com, Jennifer Host jhostmd@gmail.com, Lynn Flowers lflowers@apollomd.com, Marlon Fisher mfisher6@hotmail.com, Mike Webb mwebbkay@aol.com, Raul Rodon rrodon@apollomd.com, Richisa Johnson-Hamilton richisa@aol.com, Robert Cox rjcox01@aol.com, Robert Hull rhullmd@yahoo.com, Shannon Howell showell727@yahoo.com, Swetang Desai spd4977@yahoo.com, Theltonia Howard thelhoward@yahoo.com, Tony Polk tonepolk@yahoo.com, Wesley Leigh wesleyleigh@aol.com, Chris Pitts chrispittspac@hotmail.com, Dawn Adams daadams66@comcast.net, Kacie Jones kacieleigh1@aol.com, Leimbach, Jennifer jennifer.leimbach@lmunet.edu, Pohl, Melanie unvmel12@hotmail.com, Pryor, Anita anitapryor@att.net, Scott Anderson seapac65@yahoo.com, Short, Dennis shrtdnns@aol.com, Stephanie Jackson stephanieb.jackson@yahoo.com, Tonya Ogletree tonyaogletree@gmail.com, Young, Daniel1 danyoungpac@gmail.com

DA

This is a reminder to all of you who use scribes, that not only does the scribe have to put a note in the chart stating that he/she is acting as a scribe for you, but YOU must put a note in the chart that you agree with the scribe's documentation. Yours should read, "I, ___ ___, MD, agree with the scribe's documentation." This MUST be on each chart on which you've used a scribe, and the statement can be built as a macro.

Please also remember to SIGN every chart on which you document. To be safe, physicians can "verify" the mid-levels' charts, but still sign them as well. I know this is an extra step but the charts aren't flowing to Apollo otherwise. I think we are all getting the hang of the system, but if you aren't already aware, do NOT create a new note if you've taken over from your scribe or a midlevel; just modify their note.

For the mid-levels, please remember to assign each chart to a doctor. I may give you a list of charts asking you to assign a doctor, when you may have already done so—I can't see who you've assigned until they have signed the chart. If you get such a list and you've already assigned the doctor/s/, please just call or email me and say, "I assigned all of these to Dr. X" so I know to ask Dr. X to sign them. Please remember to document procedures thoroughly. Lastly, if you are working as the triage midlevel, you are responsible for documenting the ROS and Exam on any patients who leave before seeing another provider. These will also need a doctor assigned.

As always, if you have technical questions, please contact the help desk at x5965.

Thank you,

Adrian Dawson
ApolloMD Group Coordinator
Spalding Regional Hospital
601 S. 8th St
Griffin, GA 30224
phone 770-228-2721, x2150
fax 770-467-6138
adrian.dawson@tenethealth.com

10. There is no supervisory or regulatory requirement that Apollo do this. The *only* reason Apollo requires physicians to sign all mid-level charts in this way is so that Apollo can bill all charts under the physician's NPI. This necessarily means that Apollo submits fraudulent

claims to government payors because Apollo bills under a physician's NPI *even when the signing physician had no contact with the patient whose chart Apollo required them to sign*.

11. Apollo perpetuates this Scheme in part by paying its physicians kickbacks to sign mid-level charts—a violation of the federal Anti-Kickback Statue. Apollo credits and pays physicians for each patient they actually see *and* for each mid-level chart they sign, which substantially increases the physicians' compensation. Relator experienced this first hand while working for Apollo. Apollo uses this kickback to induce physicians to sign charts, allowing Apollo to then improperly submit mid-level charts at the full physician rate, thereby swindling the federal government and taxpayers out of significant sums of money.

12. Relator's own payment history directly reflects the fraudulent billing and the kickbacks that Apollo paid him under the Scheme. The screenshot below (from Relator's internal employee payment portal at ApolloMD.net) reflects the total number of patients that Relator supposedly treated with a mid-level in a given pay period at Apollo's Spalding Regional Medical Center (column labeled "Pts w/ MLP," which refers to mid-level providers). The chart also reflects the total compensation Relator received in a given pay period for supposedly treating patients with a mid-level (column labeled "$ Generated MLP Patients"). However, Relator in all likelihood did not actually see *any* of the patients with a mid-level because physicians at Apollo facilities rarely treat patients "with a mid-level provider." Instead, Apollo simply required Relator to sign and attest to the charts prepared by mid-levels so Apollo could bill the chart under Relator's physician NPI. Then, with that extra dollars obtained through the fraud, Apollo pays physicians a kickback. Thus, all amounts under the column labeled "$ Generated MLP Patients" on the chart below are illegal kickbacks that Apollo paid Relator under the Scheme—an amount totaling $97,378 in this instance—in just six months.

Facility	Payroll Period	Pts Dr Only	Pts w/ MLP	Pts Total	% Current MOS Pts	Current MOS Pts/Hour	Dr Hours Worked	Pts/Dr Hour, Dr Only	Pts/Dr Hour, Total (Incl MLP)	$ Generated Dr Only Pts	$ Generated MLP Patients	$ Generated Total
Spalding Regional Medical Center	7/1/16	321	274	595	97.8%	4.23	137.50	2.33	4.33	$22,158	$12,632	$34,790
Spalding Regional Medical Center	6/1/16	286	244	530	99.8%	4.11	128.50	2.23	4.12	$18,778	$10,603	$29,381
Spalding Regional Medical Center	5/1/16	305	237	542	96.5%	4.32	121.00	2.52	4.48	$20,330	$10,052	$30,381
Spalding Regional Medical Center	4/1/16	372	314	686	99.0%	4.28	158.50	2.35	4.33	$25,673	$13,926	$39,599
Spalding Regional Medical Center	3/1/16	381	351	732	99.9%	4.40	166.00	2.30	4.41	$26,141	$15,979	$42,120
Spalding Regional Medical Center	2/1/16	392	357	749	99.3%	4.65	160.00	2.45	4.68	$26,230	$15,723	$41,953
Spalding Regional Medical Center	1/1/16	382	429	811	97.2%	4.92	160.00	2.39	5.07	$26,288	$18,463	$44,752

13. The above chart also demonstrates the impossibility of physicians *actually* treating patients with a mid-level at the frequency Apollo would like CMS to believe. Indeed, the sum of the number of patients treated by a "Dr. only" and the number of patients treated "w/ MLP" adds up to an impossible number of patients to be seen by a single physician each month—as many as 811 patients in the month of January 2016. As Relator worked approximately 15 days per month at Apollo, that would mean Relator would have to physically treat more than 54 patients each and every shift during that month to reach 811 patients. That is not physically possible. This is called an "impossible day" analysis, a technique that auditors employ to discover or confirm billing fraud.

14. The graphical depiction below also falsely shows that Relator often treated patients with mid-levels at Apollo's Atlanta Medical Center-South. However, Relator only treated patients with or in conjunction with a mid-level in less than 1% of cases.

All Sonyika, Chionesu All

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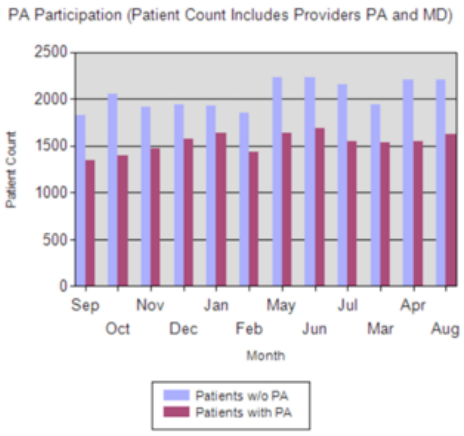
Hospital	Month	Year	Patients Dr. Only	Patients w/Mid-Level	Patients Total
AMC South	Sep	2010	1	0	1
AMC South	Oct	2010	161	17	178
AMC South	Nov	2010	92	32	124
AMC South	Dec	2010	50	24	74
AMC South	Jan	2011	73	16	89
AMC South	Feb	2011	50	34	84
AMC South	May	2011	90	54	144
AMC South	Jun	2011	35	28	63
AMC South	Jul	2011	35	21	56
AMC South	Sep	2011	18	9	27
AMC South	Oct	2011	68	35	103
AMC South	Nov	2011	58	23	81
AMC South	Dec	2011	74	38	112
AMC South	Jan	2012	123	80	203
AMC South	Feb	2012	95	62	157
AMC South	Mar	2012	173	117	290
AMC South	Apr	2012	169	68	237
AMC South	May	2012	197	117	314
AMC South	Jun	2012	219	97	316
AMC South	Jul	2012	145	87	232



15. Apollo does not hide the fact that it pays these kickbacks. In fact, Apollo regularly acknowledges that physician chart signing is *directly* tied to compensation. For example, in the September 25, 2014 email below from Adrian Dawson to numerous healthcare providers, Dawson again reminds Apollo physicians that not signing charts directly affects their paychecks.

From: **Dawson, Adrian** ADRIAN.DAWSON@tenethealth.com
Subject: end of month/charts/closing
Date: September 25, 2014 at 10:53 AM
To: Alice Fray amfray@aol.com, Camille Miller cam79miller@gmail.com, Chionesu Sonyika drsonyika@yahoo.com, Dana Woodhall danawoodhall@yahoo.com, Demetrios Tavoulareas demtav@gmail.com, Dmowski, Andrzej a.dmowski@tenethealth.com, Dr Dmowski flerdoc@gmail.com, Dwayne Greene dgreenemd@gmail.com, Fun Fong fun.fong.jr@gmail.com, Jehangir Pirzada pirzadaj@gmail.com, Jennifer Host jhostmd@gmail.com, Manish Vig manishvig@hotmail.com, Richisa Johnson-Hamilton richisa@aol.com, Robert Cox rjcox01@aol.com, Robert Hull rhullmd@yahoo.com, Swetang Desai spd4977@yahoo.com, Tony Polk tonepolk@yahoo.com, Trushnaa Patel tpatel27@gmail.com, Wesley Leigh wesleyleigh@aol.com, Chris Pitts chrispittspac@hotmail.com, Dawn Adams daadams66@comcast.net, Dennis Short shrtdnns@aol.com, Duffy, Andrew medduff44duff@gmail.com, Greg Mccollum mccollumhugh@aol.com, Jennifer Leimbach jennifer.leimbach@lmunet.edu, Mildenberger, Jason jm2848@nova.edu, Pohl, Melanie unvmel12@hotmail.com, Pryor, Anita anitapryor@att.net, Satchell, Tiffany tsatchellpac@gmail.com, Tonya Ogletree tonyaogletree@gmail.com, Young, Daniel1 danyoungpac@gmail.com

Good morning, everyone. Once again, our closing this month will be very tight and Apollo expects ALL providers to get their deficiencies and unsigned charts under control **now** and to stay that way. We currently have 300 unsigned or deficient charts, which puts us at 92%--FAR from goal! Please make sure you finish the lists I give you and clear out your message center and saved documents right away. Remember physicians, your unsigned charts DIRECTLY affect your paycheck!

Most of you are very good about this so I'm not speaking to you—THANK YOU for staying on top of things! If your list is routinely larger than a sticky note, please become better about completing your lists promptly and signing ALL of your charts at the end of your shift or at the very latest, at the start of your next shift. Nearly two years after going live with Cerner, we are expected to be the example for the facilities that have just switched to it….and we are not setting a very good one.

Please let me know if there is any reason you cannot complete your charts before the end of the month, as I must report that to ApolloMD.

Thank you,
Adrian Dawson
ApolloMD Group Coordinator
Spalding Regional Hospital
601 S. 8th St
Griffin, Georgia 30224
Office: 770.228.2721, x2150
Fax: 770.467.6138
adrian.dawson@tenethealth.com

And in the following September 26, 2013 email from Dawson to numerous Apollo healthcare providers, Dawson acknowledges that charting affects *everyone's* paychecks.

From: **Dawson, Adrian** ADRIAN.DAWSON@tenethealth.com
Subject: Month end closing
Date: September 26, 2013 at 12:34 PM
To: Alice Fray amfray@aol.com, Boykin Robinson brobinson@apollomd.com, Camille Miller cam79miller@gmail.com, Charles Chandler chrlschandler@yahoo.com, Chionesu Sonyika drsonyika@yahoo.com, Denis Kim denisjkim@yahoo.com, Fun Fong fun.fong.jr@gmail.com, Jennifer Host jhostmd@gmail.com, Lynn Flowers lflowers@apollomd.com, Marlon Fisher mfisher6@hotmail.com, Mike Webb mwebbkay@aol.com, Richisa Johnson-Hamilton richisa@aol.com, Robert Cox rjcox01@aol.com, Robert Hull rhullmd@yahoo.com, Shannon Howell showell727@yahoo.com, Swetang Desai spd4977@yahoo.com, Theltonia Howard thelhoward@yahoo.com, Tony Polk tonepolk@yahoo.com, Trushnaa Patel tpatel27@gmail.com, Wesley Leigh wesleyleigh@aol.com, Chris Pitts chrispittspac@hotmail.com, Dawn Adams daadams66@comcast.net, Kacie Jones kacieleigh1@aol.com, Leimbach, Jennifer jennifer.leimbach@lmunet.edu, Pohl, Melanie unvmel12@hotmail.com, Pryor, Anita anitapryor@att.net, Satchell, Tiffany tsatchellpac@gmail.com, Scott Anderson seapac65@yahoo.com, Short, Dennis shrtdnns@aol.com, Stephanie Jackson stephanieb.jackson@yahoo.com, Tonya Ogletree tonyaogletree@gmail.com, Young, Daniel1 danyoungpac@gmail.com

DA

Good afternoon, everyone. I was on a conference call this morning with the Group Coordinator supervisors and Roger Murray, ApolloMD's COO. They all stressed that this month-end closing will be particularly tight due to the way the dates fall. Your paychecks as well as everyone else's in the company directly relate to how much money is brought in, which is directly tied to charting. Therefore, it is ***extremely*** important that we get all September charts completed and coded as soon as possible, and EVERY chart should be complete before next Wednesday, October 2nd, so the coders have time to code them. Please check your message center and saved documents before you leave each shift, and complete any lists I give you the day I give them to you. Most of you are very good about this, and I appreciate it! For those of you with longer lists, please work on completing them NOW so the coders are not deluged at the last minute, and work to keep your charts current between now and the end of the month.

Thank you,
Adrian Dawson
ApolloMD Group Coordinator
Spalding Regional Hospital
601 S. 8th St
Griffin, Georgia 30224
Office: 770.228.2721, x2150
Fax: 770.467.6138
adrian.dawson@tenethealth.com

16. If Apollo followed CMS regulations, it would not require physicians to sign mid-level charts for patients only seen by mid-levels. Indeed, this carelessly and unnecessarily exposes physicians to litigation risk that might arise from the mid-level services over which the physicians had no control or input. However, because Apollo would only receive 85% of the physician's rate in reimbursement from CMS if it abided by CMS regulations, it chooses profits over following the law and protecting its physicians. Thus, Apollo intentionally and/or knowingly submits false claims to government payors under the Scheme because it intends to receive this additional 15% by falsely indicating that split/shared visits occurred—which it falsely indicates by requiring physicians to sign *all* mid-level charts. Then, fueling the Scheme,

Apollo uses part of this 15% in ill-gotten gains to pay its physicians the illegal kickbacks referenced above, incentivizing the chart-signing and arguably appeasing any physicians concerned with the increased risk exposure. Importantly, Apollo would not be paying its physicians these kickbacks unless Apollo itself was receiving the fraudulently-obtained 15% in split/shared visit reimbursements under the Scheme.

17. Apollo's Scheme violates CMS billing regulations and guidelines and causes the knowing and/or intentional submission of illegal and false claims for reimbursement under federal and state laws. It involves illegal physician kickbacks in violation of federal law. It defrauds federal and state health care programs on a nationwide basis. And, it costs taxpayers significant sums of money each year. In this action, Relator seeks recovery of damages and civil penalties under the federal False Claims Act and similar state laws, and the Anti-Kickback Statute on behalf of the United States of America and the Plaintiff States arising from Apollo's perpetration of the Scheme.

II. PARTIES

A. RELATOR Chionesu Sonyika, M.D.

18. Relator CHIONESU KWESI SONYIKA, M.D., is a citizen of the United States of America who currently resides in the State of Georgia. Dr. Sonyika is currently licensed to practice medicine in Georgia and North Carolina. He is certified by the American Board of Emergency Medicine (ABEM) and was residency-trained specifically in emergency medicine. He brings this *qui tam* action based upon direct and unique information obtained during his employment in the emergency department at the Atlanta Medical Center-South in Atlanta, Georgia and Spalding Regional Medical Center in Griffin, Georgia, where he worked from 2010 to 2018 as an independent contractor physician for Apollo. Through his work at these Apollo-

managed emergency departments, Dr. Sonyika has acquired direct personal knowledge of and non-public information about Apollo's fraudulent billing for reimbursement from federal and state healthcare payers.

B. DEFENDANTS

19. Defendants are a system of affiliated entities controlled by the same individuals and entities, operating out of the same principal office, and collectively referred to herein as "Apollo." Apollo is a privately-held, physician-led national group practice that provides staffing and management services to hospitals in the United States, specifically in the areas of emergency medicine, hospital medicine, radiology, and anesthesiology. Apollo is headquartered in Atlanta, Georgia, and has a presence at hospitals and healthcare centers in at least sixteen (16) states. It partners with several major health systems and over 140 individual hospitals and surgery centers nationwide. Apollo employs over 2,000 clinical workers, primarily as independent contractors.

20. Defendant APOLLOMD BUSINESS SERVICES, LLC, is a Georgia limited liability company that maintains its principal place of business and principal office at 5665 New Northside Drive, Suite 320, Atlanta, Georgia, 30328.

21. Defendant, INDEPENDENT PHYSICIANS RESOURCE, INC., is a subsidiary of ApolloMD Business Services, LLC, that is incorporated in Georgia and maintains its principal place of business and principal office at 5665 New Northside Drive, Suite 320, Atlanta, Georgia, 30328, and also is registered to do business in, *inter alia*, the State of Florida.

22. Defendant, APOLLOMD, INC., is a subsidiary of both ApolloMD Business Services, LLC, and Independent Physicians Resource, Inc., that is incorporated in Georgia and maintains its principal place of business and principal office at 5665 New Northside Drive, Suite 320, Atlanta, Georgia, 30328.

23. Defendant, APOLLOMD HOLDINGS, LLC, is a subsidiary of both ApolloMD Business Services, LLC, and Independent Physicians Resource, Inc., that is organized under the laws of Georgia and maintains its principal place of business at 5665 New Northside Drive, Suite 320, Atlanta, Georgia, 30328.

24. Defendant, PAYMENTSMD, LLC, is a subsidiary of both ApolloMD Business Services, LLC, and Independent Physicians Resource, Inc., that is organized under the laws of Georgia and maintains its principal place of business and principal office at 5665 New Northside Dr., Suite 320, Atlanta, Georgia, 30328.

25. Defendant, APOLLOMD GROUP SERVICES, LLC, is a subsidiary of both ApolloMD Business Services, LLC, and Independent Physicians Resource, Inc., that is organized under the laws of Georgia and maintains its principal place of business and principal office at 5665 New Northside Dr., Suite 320, Atlanta, Georgia, 30328.

26. Defendant, APOLLOMD PHYSICIAN PARTNERS, INC., is a subsidiary of both ApolloMD Business Services, LLC, and Independent Physicians Resource, Inc., that is incorporated in Georgia and maintains its principal place of business and principal office at 5665 New Northside Dr., Suite 320, Atlanta, Georgia, 30328.

27. Defendant APOLLOMD PHYSICIAN SERVICES FL, LLC, is a subsidiary of both ApolloMD Business Services, LLC, and Independent Physicians Resource, Inc., that is organized under the laws of Florida and maintains its principal place of business and principal office at 5665 New Northside Dr., Suite 320, Atlanta, Georgia, 30328.

28. Defendant, GEORGIA EMERGENCY GROUP, LLC, is a subsidiary of both ApolloMD Business Services, LLC, and Independent Physicians Resource, Inc., that is organized

under the laws of Georgia and maintains its principal place of business and principal office at 5665 New Northside Drive, Suite 320, Atlanta, Georgia, 30328.

29. Because Apollo is a privately held company that consists of multiple business entities, other Apollo-related entities, including parents, subsidiaries, and affiliates, may also be involved in the fraudulent Scheme alleged herein. However, such involvement of other Apollo-related entities cannot be discerned based on public information or other information available to Relator, absent the discovery process.

III. VENUE, CONDITIONS PRECEDENT, AND JURISDICTIONAL ALLEGATIONS

30. This Court has jurisdiction over this action under 31 U.S.C. § 3732(a) and 28 U.S.C. §§ 1331 and 1345 because this civil action arises under the laws of the United States.

31. Relator brings this action under the FCA, 31 U.S.C. § 3729 *et. seq.*, to recover treble damages, civil penalties, and costs of suit, including reasonable attorneys' fees and expenses. Relator has authority to bring this action and these claims on behalf of the United States pursuant to 31 U.S.C. §§ 3730(b) and 3730(e)(4), and Relator has satisfied all conditions precedent to participate as Relator. Pursuant to 31 U.S.C. § 3730(e)(4)(A), the allegations contained herein have not been publicly disclosed as defined by the FCA, or alternatively, Relator qualifies as an "original source" within the meaning of 31 U.S.C. § 3730(e)(4)(A) and (B). Pursuant to 31 U.S.C. 3730(e)(4)(B), Relator has voluntarily provided in writing to the Attorney General of the United States and the United States Attorney's Office for the Southern District of Florida, prior to filing this complaint, substantially all material evidence and information in Realtor's possession upon which these allegations are based. In accordance with 31 U.S.C. § 3730(b)(2), Relator served the United States pursuant to Federal Rule of Civil Procedure 4 prior to filing this complaint.

32. This Court has jurisdiction over Relator's state law claims pursuant to 31 U.S.C. § 3732, as those claims arise from the same transaction or occurrence as Relator's claim under § 3729. Additionally, this Court has supplemental jurisdiction over Relator's state law claims pursuant to 28 U.S.C. §1367(a), as those claims form part of the same case or controversy under Article III of the United States Constitution as Relator's claim under the federal FCA. Relator has complied with all state law procedural requirements, including service upon the appropriate state Attorneys General prior to filing this action.

33. This Court may exercise personal jurisdiction over Apollo because Apollo transacts, operates, conducts, engages in, and carries out substantial business within the State of Florida, in accordance with the Florida Long-Arm Statute, Fla. Stat. § 48.193(1)-(2). Moreover, Apollo purposefully directs its services at the State of Florida, thereby purposefully availing itself of the privilege of conducting business within the State of Florida and invoking the benefits and protections of its laws. This action arises out of that conduct. This Court's exercise of jurisdiction over the Defendant does not offend traditional notions of fair play and substantial justice.

34. Venue is proper in the Southern District of Florida pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391(b)–(c). Apollo can be found in, resides in, transacts, and/or has during the relevant time period transacted substantial business in this judicial District. Additionally, one or more of the Defendants committed acts proscribed by 31 U.S.C. § 3729 in this judicial District by perpetrating the Scheme described herein within the Southern District of Florida. Specifically, during the relevant time period, Apollo has transacted business with and/or on behalf of at least the following healthcare providers and hospitals located within the Southern District of Florida: (1) the Coral Gables Hospital in Coral Gables, Miami-Dade County, Florida;

(2) the Palmetto General Hospital in Hialeah, Miami-Dade County, Florida; (3) the Hialeah Hospital in Hialeah, Miami-Dade County, Florida; (4) the Indian River Medical Center in Vero Beach, Indian River County, Florida; (4) the St. Mary's Medical Center in West Palm Beach, Palm Beach County, Florida; (5) the Good Samaritan Medical Center in West Palm Beach, Palm Beach County, Florida; (6) the West Boca Medical Center in West Boca, Palm Beach County, Florida.

IV. MEDICARE AND MEDICAID PROGRAMS

The Medicare Program and Federal Administration

35. Medicare[3] is a federally funded program administered by CMS[4] that provides "nearly every American 65 years of age and older a broad program of health insurance designed to assist the nation's elderly to meet hospital, medical, and other health costs."[5] Medicare is funded in part by taxpayer revenue. In 2014, Medicare spending totaled $618.7 billion and accounted for 20% of the total healthcare spending in the United States.[6] Unfortunately, "[f]raud and systematic overcharging are estimated at roughly $60 billion, or 10 percent, of Medicare's costs every year."[7]

36. Medicare is comprised of three primary insurance programs—Medicare Parts A, B and D—that cover different types of healthcare needs.[8] Medicare Part A (Hospital Insurance)

[3] Medicare is the popular name for the Health Insurance for the Aged and Disabled Act, which is title XVIII of the Social Security Act.
[4] CMS is part of the Department of Health and Human Services ("DHHS").
[5] CMS, MEDICARE GENERAL INFORMATION, ELIGIBILITY, AND ENTITLEMENT MANUAL, pub. 100-01, Ch. 1 § 10 (2015), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c01.pdf (hereinafter "MEDICARE GENERAL INFORMATION MANUAL").
[6] NHE FACT SHEET, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html (last visited Mar. 10, 2016).
[7] Reed Abelson & Eric Lichtblau, *Pervasive Medicare Fraud Proves Hard to Stop*, N.Y. TIMES, Aug. 15, 2014, http://www.nytimes.com/2014/08/16/business/uncovering-health-care-fraud-proves-elusive.html.
[8] Medicare also includes Medicare Part C (also called Medicare Advantage), which is not a separate benefit, but a program whereby private companies approved by Medicare provide coverage under Medicare Part A and Part B. *See* HOW DO MEDICARE ADVANTAGE PLANS WORK?," https://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/how-medicare-advantage-plans-work.html (last visited Dec. 12, 2016).

covers institutional care such as inpatient hospital care, nursing services, drugs and biologicals necessary during an inpatient stay, and other diagnostic or therapeutic services.[9] Medicare Part B (Supplementary Medical Insurance) covers non-institutional care such as physician services, medical equipment and supplies, and services performed by qualified mid-levels under the supervision of a physician.[10] Medicare Part D (Drug Coverage) covers the cost of prescription drugs.[11]

37. Under Medicare's programs, the federal government reimburses healthcare providers for their labor and medical decision-making on a fee-for-service basis according to predetermined fee schedules, including the Medicare Physician Fee Schedule ("MPFS"), which establishes annual rates for more than 10,000 services provided by physicians and other healthcare professionals.[12] The rates established in the MPFS correspond to specific five-digit codes associated with each medical procedure or service provided. The American Medical Association publishes these Current Procedural Terminology ("CPT") codes annually.

38. The process by which healthcare services are submitted and reimbursed involves several steps and various entities. First, physicians and mid-levels must clearly and sufficiently document patient encounters in their medical charts. To ensure that documentation is clear and complete, CMS has developed specific documentation guidelines that it requires healthcare providers to use—the 1995 Documentation Guidelines for Evaluation and Management Services

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[9] CMS, MEDICARE BENEFIT POLICY MANUAL, pub. 100-02, Ch. 1, Table of Contents (2014), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf (hereinafter "MEDICARE BENEFIT POLICY MANUAL").

[10] MEDICARE GENERAL INFORMATION MANUAL at Ch. 1 § 10.3. Medicare Part B also covers emergency department services. *See* MEDICARE.GOV, EMERGENCY DEPARTMENT SERVICES, https://www.medicare.gov/coverage/emergency-dept-services.html (last visited Mar. 10, 2016).

[11] MEDICARE.GOV, DRUG COVERAGE (PART D), https://www.medicare.gov/part-d/ (last visited Mar. 29, 2016).

[12] *See* CMS, HOW TO USE THE SEARCHABLE MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) at 1 (Apr. 2014), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/How_to_MPFS_Booklet_ICN901344.pdf. CMS also has fee schedules for ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics and supplies. FEE SCHEDULES – GENERAL INFORMATION, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html?redirect=/feeschedulegeninfo (last visited Dec. 12, 2016).

and 1997 Document Guidelines for Evaluation and Management Services.[13] Through the Evaluation and Management ("E/M") documentation process, providers document their medical decision-making and care during a patient encounter so that billing department coders can translate those services into the required CPT codes for billing purposes.[14]

39. In addition to selecting the appropriate CPT codes, the coder must identify the appropriate provider who provided the services and submit that provider's National Provider Identifier ("NPI") and Provider Transaction Access Number ("PTAN") for billing. The NPI identifies the individual healthcare provider that performed the services to be reimbursed. The PTAN identifies the practice group or company for whom the provider works.

40. CMS reimburses different types of healthcare providers at different rates. For example, as discussed in detail below, CMS typically reimburses mid-levels at 85% of the full physician rate under federal statute and CMS regulations. As such, any claim submitted to CMS must include the appropriate provider's NPI to avoid improper billing, as the NPI triggers the billing rate for any particular E/M service. Once the coder has assigned the appropriate CPT codes and NPI for a particular patient encounter, the claim is submitted to a fiscal intermediary called a Medicare Administrative Contractor ("MAC") based on geographical location. The MAC then processes the claims it receives and reimburses the provider according to Medicare's fee schedule. MACs are typically private insurance companies that have been contracted by the federal government to process medical claims, and are responsible for the majority of enforcement efforts when it comes to Medicare claims. For its part, CMS "manually reviews

[13] Providers may use either the 1995 or the 1997 Guidelines, but not a combination of the two.

[14] *See* CMS, EVALUATION AND MANAGEMENT SERVICES GUIDE at 3-5 (November 2014), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf.

just three million of the estimated 1.2 billion claims it receives each year"—or 0.25% of all claims submitted.[15] Thus, over 99% of submitted claims are never actually review by CMS.

The Medicaid Program and State Administration

41. The Medicaid Program ("Medicaid") is a Health Insurance Program administered by the Government of the United States and state agencies that is funded by state and federal taxpayer revenue. The United States Health and Human Services Department oversees the administration of the program. Medicaid was designed to assist participating states in providing medical services, durable medical equipment, and prescription drugs to financially-needy individuals that qualify for Medicaid.

42. While the federal government sets basic guidelines and pays between 50% and 80% of the cost of Medicaid (depending on the state's per capita income), each state itself administers the program, decides provider qualifications, and reimburses providers.

43. Under Title XIX of the Social Security Act, each state must establish an agency to administer its Medicaid program according to federal guidelines. The following table provides the Plaintiff States' Medicaid administrative agency and designated program name.

State	Department	Medicaid Program Name
Florida	Agency for Health Care Administration	Florida Medicaid
Georgia	Department of Community Health	Georgia Medicaid
Indiana	Office of Medicaid Policy and Planning	Indiana Health Coverage Programs
Iowa	Department of Human Services—Iowa Medicaid Enterprise	Iowa Medicaid
Tennessee	Division of Health Care Finance and Administration	TennCare
Texas	Health and Human Services Commission	Texas Medicaid

[15] Reed Abelson & Eric Lichtblau, *Pervasive Medicare Fraud Proves Hard to Stop*, N.Y. TIMES, Aug. 15, 2014, http://www.nytimes.com/2014/08/16/business/uncovering-health-care-fraud-proves-elusive.html.

V. FACTUAL ALLEGATIONS

A. BACKGROUND

44. Apollo is among the nation's most profitable physician practice management companies ("PPMs"), which provide management and human-resources services to hospitals and, in particular, to emergency departments. Apollo bases its business model not on quality of care but on reducing emergency department costs and increasing their revenues. Apollo's revenue-based business model is built on three primary goals: (1) treat and bill more patients by increasing "patient throughput and allowing for volume growth"[16]; (2) implement standard coding and billing procedures to capture as much revenue as possible from CMS and private payers; and (3) align physicians' incentives with hospitals' incentives by compensating physicians based on the number of "patients they treat and the procedures they perform."[17]

45. First, an integral part of Apollo's business model is moving patients through the emergency department as quickly as possible—*i.e.*, increasing "throughput." To accomplish this, Apollo uses a floor-management model that often physically segregates physicians and mid-levels in different areas of the emergency department. These floor-management models enable Apollo to increase revenue by: (1) increasing the volume of patients treated; and (2) using lower cost staffing, such as PAs and NPs, to treat more patients instead of expensive physicians.

46. Second, Apollo's business model relies on the implementation of national, standardized billing and coding practices aimed at capturing as much revenue as possible from third-party payers like CMS. Apollo touts its in-house billing company, which has the ability to "utilize electronic records to maximize control and efficiency in the billing process, and continually leverage our size and legal expertise to successfully negotiate with managed care

[16] http://apollomd.com/home/multispecialty-solutions/emergency-medicine/ (last visited Dec. 10, 2016).
[17] *Id.*

providers in order to maximize reimbursement."[18] Coding is the process by which a patient's medical chart is translated into billable services that are then submitted to CMS (or private insurers) for reimbursement. Apollo's standardized coding techniques are aimed at milking every last cent out of each medical chart.

47. Finally, Apollo seeks to increase revenue by aligning physicians' incentives with hospitals' incentives. Apollo does this by compensating physicians based on the number of "patients they treat and the procedures they perform."[19] Apollo employs its emergency department physicians, like Dr. Sonyika, as independent contractors and compensates these physicians based upon a fixed-rate fee schedule agreed to by contract. Apollo also pays its physicians a kickback for services provided by mid-levels even when there is no physician involvement, compensating physicians for each mid-level chart they sign. Thus, physicians are financially incentivized to bring in as much revenue as possible—by treating patients and signing mid-level charts, which in turn increases Apollo's revenues.

B. APOLLO'S FRAUDULENT SCHEME

48. Relator has witnessed first-hand the unlawful practices that Apollo utilizes to fraudulently increase billing to and reimbursement from CMS. Through his personal knowledge, experience, and investigation, Relator has uncovered the unlawful scheme that Defendants systematically and purposely use to submit false claims to CMS (the "Scheme"). Under the Scheme, Apollo overbills for services provided by mid-levels (*i.e.*, PAs and NPs) by fraudulently submitting claims for reimbursement for those services under a physician's NPI to be paid at the higher physician rate. That is, although Apollo submits claims to CMS for reimbursement for mid-level services, it falsely indicates that a physician, rather than a mid-level, performed the

[18] *Id.*
[19] *Id.*

services. Apollo does this because CMS reimburses for physician services at a higher rate than mid-levels services.

49. Typically, services provided by mid-levels are reimbursed at 85% of the physician billing rate for E/M services.[20] *See* 42 U.S.C. § 1395l(a)(1)(O). To determine the allowable rate for a service provided by a mid-level, Medicare will select the proper amount based on the physician fee schedule and discount that amount by 15% to reach the appropriate 85% mid-level billing rate. The Plaintiff States have enacted similar reimbursement protocols for their Medicaid programs. When a mid-level performs services alone, without physician involvement, the proper procedure is to submit a claim for those services under the mid-level's name and NPI so the claim will be paid at the appropriate mid-level rate.

50. In the vast majority of circumstances, mid-levels and physicians in Apollo's emergency departments treat patients separately. Under Apollo's business model—which is focused on maximizing efficiency and profits—physicians and mid-levels rarely, if ever, work alongside each other or treat the same patients in a true split/shared visit. Mid-levels treat lower acuity patients, and physicians treat higher acuity patients. *See* Exhibit 1. Accordingly, the vast majority of claims submitted by Apollo for services provided by its emergency department mid-levels should be submitted under the mid-levels' NPIs. However, that it not what Apollo does.

51. Despite the fact that mid-levels perform the vast majority of their services alone, Apollo uniformly submits claims for services provided *solely* by mid-levels under physician NPIs. Indeed, there can be no dispute regarding Apollo's uniform fraudulent billing practice, as

[20] The Medicare statute specifically states, "with respect to services described in 1861(s)(2)(K) [42 USCS § 1395x(s)(2)(K)] (relating to services furnished by physician assistants, nurse practitioners, or clinic nurse specialists), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848 [42 USCS § 1395w-4], or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery[.]" 42 U.S.C. § 1395l(a)(1)(O).

Apollo's Chief Operations Officer and Chief Quality Officer admitted (perhaps unwittingly) this fraud in an internal email sent on December 2, 2016, to all emergency physicians working for Apollo. *See* Exhibit 1 attached hereto.

52. In this nationwide mass email, the Apollo executives explain how Apollo measures certain data that it submits to CMS's Physician Quality Reporting System ("PQRS"). *Id.* The PQRS was a CMS program under which healthcare providers like Apollo provided Medicare beneficiary data and charts to CMS.[21] If the data was not submitted to CMS, then the healthcare provider would receive a penalty reduction in reimbursement. Unsurprisingly, then, the PQRS was a CMS program that profit-driven Apollo actually *did* follow.

53. The data Apollo submitted to CMS for the PQRS was based on ***actual claims submitted*** by Apollo to CMS for services Apollo provided to Medicare beneficiaries under the fee-for-service schedule. After Apollo began participating in the PQRS program, it produced reports to its physicians to show the results of the quality measures, as one of the goals of the PQRS program was to improve patient care. These reports were also based on actual claims data from Medicare billing submissions. After reviewing reports based on claims data, certain Apollo physicians had some questions about how the PQRS systems work and what was included in the reports, which allegedly reflected the quality of the care those physicians were providing. The physicians directed these questions to Apollo executives and at meetings, and Apollo's Chief Operations Officer and Chief Quality Officer answered some of these questions in the December 2, 2016 email referenced above. *Id.* Specifically, after reviewing the reports, the physicians questioned why certain services had been attributed to them when they did not actually perform the services. Physicians questioned whether the reports included the mid-level or APC

[21] *See* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_OverviewFactSheet_2013_08_06.pdf (last visited October 24, 2019).

(advanced practice clinicians—another term for mid-level) charts that the physicians simply sign. In the relevant portion of the email (depicted below), Apollo executives spell out the exact questions and then provide the answers:

> *Q: Do the PQRS measures include those patients that are APC charts that I sign, or are they my charts alone?*
> A: The charts are a combination of both "physician only" charts and "physician/APC charts". As the charts are billed under the physician NPI number, both will count equally for adjustments by CMS. For this reason, all charts attributed to the physician are included.
>
> *Q: Do the CT Reports include those patients that are APC charts that I sign, or are they my charts alone?*
> A: Same answer. The CT utilization data is a combination of both "physician only" charts and "physician/APC charts". As the charts are billed under the physician NPI number, we are accountable for the physician as well as the APC charts. As APCs tend to see less acute patients, this can actually make our CT utilization rate less. And as above, we are ultimately responsible for APC patients and the quality of the care they deliver to our patients.

54. The executives first answer the question "Do the PQRS measures indicate those patients that are APC [i.e., mid-level] charts that I sign, or are they my charts alone?" In other words, the question asks which charts form the basis of the PQRS reports: either (1) mid-level charts that the physician signed, but for which the physician had no face-to-face patient contact, or (2) the charts of patients only treated by the physician. Apollo's answer: "The charts are a combination of both 'physician only' charts and 'physician/[mid-level] charts.' As the charts are billed under the physician NPI number, both will count equally for adjustments by CMS. For this reason, all charts attributed to the physician are included." **This is more than a reliable indicia of fraud. This is an *admission* of actual false claims submitted.**

55. In its answer, Apollo admits two things. First, that it bills *all* APC/mid-level charts "under the physician NPI number." This is fraudulent *unless* a true split/shared visit occurred. However, the question itself demonstrates that split/shared visits are not at issue here, as it refers "APC charts that I *sign*," not for example, "patients I treated with an APC." And,

Apollo physicians *rarely if ever* actually treat the same patients as mid-levels. Indeed, the fact that the COO put the phrase "physician/APC charts" in quotations further confirms this point. Thus, the answer admits fraud: that Apollo bills under a physician's NPI for "physician/APC charts," which in reality are the mid-level charts that Apollo requires physicians to sign despite the physicians never having had face-to-face contact with the patients.[22] And because the physicians did not have face-to-face contact with these patients, it is fraudulent to bill under the physician's NPI. This is how Apollo receives reimbursement for the full physician rate when Apollo *should* only be receiving 85% of the physician rate.

56. Second, Apollo admits in its answer that it *actually submitted* false claims to CMS. This is because the charts that Apollo admits to fraudulently billing under the physician's NPI referenced above represent charts for which Apollo *already submitted actual claims to CMS*—again, because the patient chart data that Apollo submits to CMS as required by the PQRS is based on actual claims that Apollo submitted to CMS.

57. To avoid any confusion about the meaning of this email, Relator emailed Apollo's Chief Operating Officer, Amy Katnik, and asked, "What does APC stand for?" *See* Exhibit 2 attached hereto. Ms. Katnik responded that "APC" means "Advanced Clinician or midlevel." Id. Accordingly, Apollo's executives have confirmed Apollo's uniform billing practice for services provided by mid-levels is to bill for those services "under the physician NPI number." Exhibit 1.

58. As noted above, the NPI that is used triggers the reimbursement rate CMS will apply. Thus, when Apollo uses a physician NPI to request reimbursement for mid-level services (as it admits it does in the email above), CMS applies 100% of the physician rate to the request

[22] Again, Relator did not treat patients with mid-levels, but still signed all of their charts as Apollo required and incentivized.

and, therefore, reimburses Apollo for the services of a mid-level as if a physician had performed them.

59. In an attempt to cover up this fraud, Apollo manipulates patient medical charts to falsely reflect what is called a "split/shared visit."[23] A split/shared visit occurs when a mid-level performs services alongside or in conjunction with a supervising physician who provides a substantive portion of the face-to-face visit with the patient. When a true split/shared visit occurs, CMS reimburses for the mid-level services at the same rate as the physician's services, as if the mid-level were an extension of the physician. However, a true split/shared visit only occurs when the physician has a face-to-face encounter with the patient. CMS, Medicare Claims Processing Manual, pub 100-04, Ch. 12, § 30.6.1(B) ("[I]f there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the [mid-level's NPI]"). In the emergency department context, a split/shared visit is the *only* circumstance under which mid-level services may be reimbursed at the full physician rate.

60. Apollo wholly ignores these regulations by requiring physicians to add a signature and "attestation" to *all* mid-level charts, though actual physician involvement is exceedingly rare. Coding and billing specialists working for Apollo then reduce the falsified medical charts to CPT codes and select the *physician's* NPI for billing purposes, despite the fact that the physician performed no services at all. *See* Exhibit 1. The coding is then submitted to CMS for reimbursement at the full physician rate, such that the mid-level's services are reimbursed under the physician's NPI. *See id*. Thus, Apollo systematically submits false claims to CMS.

[23] Apollo is also able to conceal its fraud because E/M services are "pass through" claims for billing purposes, meaning there is no front-end auditing of these charges.

61. If in response to this Complaint Apollo questions whether Relator has pointed to *actual* claims that Apollo falsely submitted to CMS and wrongly received reimbursement for, the answer is "YES." Apollo is on specific notice and has an objective place to look for the fraudulent Scheme Relator alleges herein: As a starting place, Apollo should review all of the claims, data and charts it submitted under the Medicare PQRS program (a narrow program that no longer exists) and the related billing data.[24] This is an entirely doable and reasonable task. While Relator alleges the fraudulent Scheme is much broader than just those charts submitted as part of the PQRS program (as discovery will show) and the allegations herein should not be limited to the PQRS program, Relator has indeed pointed to specific charts and specific claims in Apollo's possession that Apollo can identify and analyze in response to this Complaint. There are additional allegations in this Complaint that also point Apollo to actual false claims submitted to and reimbursed by CMS, such as the MLP services associated with the kickbacks Relator received in the months and years shown on the screenshots from the ApolloMD.net paycheck portal. These also show actual kickbacks that Apollo paid to Relator. Further, below is a step-by-step explanation of Apollo's Scheme, kickbacks, and cover-up, including the who, what, when, where and how.

62. The Scheme starts with the floor-management models Apollo employs to increase "throughput."[25] Again, in most Apollo facilities, physicians and mid-levels work in different "zones" of the emergency department. Patients are assigned to either a physician or a mid-level depending on the severity of the patient's condition or injury. Dividing the emergency department floor plan in this way all but eliminates direct interaction between physicians and

[24] The PQRS began in 2006 and ended in 2016. Under the PQRS, Apollo submitted a limited amount of Medicare beneficiary data and charts to CMS. This included data from the Atlanta Medical Center South and the Spalding Regional Medical Center in Griffin, Georgia—where Relator worked for Apollo from 2010 to 2018.
[25] *See* http://apollomd.com/home/multispecialty-solutions/emergency-medicine/ (last visited Dec. 10, 2016).

mid-levels. This is intentional; the system prevents overlap and maximizes the number of patients each individual healthcare provider treats. However, the system also complicates communication between emergency department personnel and thereby facilitates Apollo's Scheme.

63. Those patients that are assigned to mid-levels typically receive care from the mid-level alone without any physician involvement whatsoever. Under Apollo's floor-management models, it is extremely rare that mid-levels and physicians ever see the same patient or even discuss a patient's diagnosis or treatment plan.

64. During or immediately following treatment, the mid-level will create and complete an EMR (electronic medical record) for the patient, documenting all of the elements of treatment, which will be used for coding and billing later. These elements include a detailed or comprehensive medical history, physical examination, identification of medicines administered, tests ordered, images ordered, and a description of the medical decision making required.

65. After the patient visit is over and the mid-level completes the EMR, Apollo *should* code and submit the claim to CMS for the mid-level's services *under the mid-level's NPI* so that CMS will appropriately reimburse Apollo at the 85% rate for mid-level's services. But, that is not what Apollo does. Instead, after completing the EMR, Apollo requires mid-levels to assign and send each of the charts to a physician for signature, regardless of whether the physician supervised the mid-level and actually saw the patient. Apollo even instructs mid-levels to assign their charts to physicians at random and to alternate which physician they assign their chart to so that payment for the mid-level services is equally distributed to the physicians. For example, the December 5, 2012 email (below) from Mr. Dawson instructs mid-levels to "assign each chart to a doctor." *See also* Exhibit 3 attached hereto ("Midlevels: Please remember

to reliably alternate back and forth for the doc to whom you assign pts. It affects their paycheck."). The result is that *every mid-level chart is assigned to a physician for signature* so that Apollo can, improperly, bill CMS for mid-level services at the full physician rate.

From: **Dawson, Adrian** ADRIAN.DAWSON@tenethealth.com
Subject: FirstNet
Date: December 5, 2012 at 3:38 PM
To: Alice Fray amfray@aol.com, Camille Miller cam79miller@gmail.com, Chionesu Sonyika drsonyika@yahoo.com, Denis Kim denisjkim@yahoo.com, Fun Fong fun.fong.jr@gmail.com, Jennifer Host jhostmd@gmail.com, Lynn Flowers lflowers@apollomd.com, Marlon Fisher mfisher6@hotmail.com, Mike Webb mwebbkay@aol.com, Raul Rodon rrodon@apollomd.com, Richisa Johnson-Hamilton richisa@aol.com, Robert Cox rjcox01@aol.com, Robert Hull rhullmd@yahoo.com, Shannon Howell showell727@yahoo.com, Swetang Desai spd4977@yahoo.com, Theltonia Howard thelhoward@yahoo.com, Tony Polk tonepolk@yahoo.com, Wesley Leigh wesleyleigh@aol.com, Chris Pitts chrispittspac@hotmail.com, Dawn Adams daadams66@comcast.net, Kacie Jones kacieleigh1@aol.com, Leimbach, Jennifer jennifer.leimbach@lmunet.edu, Pohl, Melanie unvmel12@hotmail.com, Pryor, Anita anitapryor@att.net, Scott Anderson seapac65@yahoo.com, Short, Dennis shrtdnns@aol.com, Stephanie Jackson stephanieb.jackson@yahoo.com, Tonya Ogletree tonyaogletree@gmail.com, Young, Daniel1 danyoungpac@gmail.com

DA

This is a reminder to all of you who use scribes, that not only does the scribe have to put a note in the chart stating that he/she is acting as a scribe for you, but YOU must put a note in the chart that you agree with the scribe's documentation. Yours should read, "I, ___ ___, MD, agree with the scribe's documentation." This MUST be on each chart on which you've used a scribe, and the statement can be built as a macro.

Please also remember to SIGN every chart on which you document. To be safe, physicians can "verify" the mid-levels' charts, but still sign them as well. I know this is an extra step but the charts aren't flowing to Apollo otherwise. I think we are all getting the hang of the system, but if you aren't already aware, do NOT create a new note if you've taken over from your scribe or a midlevel; just modify their note.

For the mid-levels, please remember to assign each chart to a doctor. I may give you a list of charts asking you to assign a doctor, when you may have already done so—I can't see who you've assigned until they have signed the chart. If you get such a list and you've already assigned the doctor/s/, please just call or email me and say, "I assigned all of these to Dr. X" so I know to ask Dr. X to sign them. Please remember to document procedures thoroughly. Lastly, if you are working as the triage midlevel, you are responsible for documenting the ROS and Exam on any patients who leave before seeing another provider. These will also need a doctor assigned.

As always, if you have technical questions, please contact the help desk at x5965.

Thank you,
Adrian Dawson
ApolloMD Group Coordinator
Spalding Regional Hospital
601 S. 8th St
Griffin, GA 30224
phone 770-228-2721, x2150
fax 770-467-6138
adrian.dawson@tenethealth.com

66. Once an EMR has been completed and assigned to a physician by a mid-level, Apollo requires physicians to add a signature and "attestation" to each EMR. Physicians have no option

to disagree with the care or documentation provided by the mid-level. Nonetheless, every emergency physician is *required* to sign and approve *every* mid-level chart sent to him or her at the end of each shift. A typical "attestation" will say something like, "I have consulted with Physician Assistant Smith and concur with the treatment she provided."

67. Apollo administrators regularly require Relator to sign the charts of mid-levels for patients whom Relator did not treat. For example, in the following February 17, 2014 email from Adrian Dawson to Relator, Mr. Dawson instructs Relator to sign all of the mid-level charts assigned to him.

From: **Dawson, Adrian** ADRIAN.DAWSON@tenethealth.com
Subject: charts
Date: February 17, 2014 at 10:09 AM
To: doc drsonyika@yahoo.com

DA

Hi, Dr. Sonyika. If you have remote access, please log in and sign all of the midlevel charts that are assigned to you; I think there are quite a few.

Thanks,
Adrian Dawson
ApolloMD Group Coordinator
Spalding Regional Hospital
601 S. 8th St
Griffin, Georgia 30224
Office: 770.228.2721, x2150
Fax: 770.467.6138
adrian.dawson@tenethealth.com

Again, there is no legitimate reasons Apollo should require physicians to sign mid-level charts for patients that the physicians did not see or treat and has no control over. Indeed, it needlessly exposes physicians litigation risk for treatment they did not provide or control. The only reason Apollo requires physicians to sign all mid-level charts in this way is so that Apollo can bill all charts under the physician's NPI—when Apollo *should* be billing solely under the mid-level's NPI for patients only treated by a mid-level. This necessarily means that Apollo submits

fraudulent claims to government payors because Apollo bills under a physician's NPI *even for patients only treated by a mid-level.*

68. Apollo hounds mid-levels to assign every chart to a physician and harasses physicians to countersign and attest to any outstanding mid-level charts. The following March 14, 2013 email from Apollo Credentialing Specialist, Liz Hawkins, is an example of the emails that Apollo administrators regularly send to physicians and mid-levels—requiring physician attestations and signatures—in furtherance of the Scheme:

From: **Liz Hawkins** lhawkins@apollomd.com
Subject: Deficient charts with Dr. Signature
Date: March 14, 2013 at 8:06 AM
To: balimd7@yahoo.com, brett.cannon@gmail.com, drsonyika@yahoo.com, gfilmore@gmail.com, gmwilliams76@gmail.com, jwwalraven@bellsouth.net, jimsonsmith2@gmail.com, anniev@hotmail.com, KIMBERLY HALL takdoves@bellsouth.net, nnkwuo@yahoo.com, tonepolk@yahoo.com, richisa@aol.com, Wazeerud-Din MD (wazeeds@hotmail.com) wazeeds@hotmail.com, T. Howard thelhoward@yahoo.com, Christina.K.Eid Christina.K.Eid@live.mercer.edu, christina.guice@yahoo.com, Darron Deal darron.deal@gmail.com, l.nichole@yahoo.com, Lyndsey Taylor lyndseymtay@gmail.com, Michael Clark michael.andrew.clark@gmail.com, reenataank@gmail.com, sarah.jeanne.clark@gmail.com sarah.jeanne.clark@gmail.com, mcsassy98@yahoo.com, sheatab@comcast.net, tikilake@gmail.com
Cc: diondavid.sfmc@gmail.com, Jody Camp jcamp@apollomd.com

LH

I'm receiving **numerous** deficient charts from coding with **Dr. Signature deficiency** which Is Physician signature and the midlevel attestation missing on the charts. **Midlevels** please be sure you make sure the Physician assigned to the patient has their signature & attestation completed. **Physicians** please make sure you go through the midlevel charts and attest with your signature that you reviewed the charting etc.

Thank you,

Liz Hawkins
Credentialing Specialist
ApolloMD
5665 New Northside Drive, Suite 320
Atlanta, Georgia 30328
Office: 404-645-7840
Fax: 678-235-6758

lhawkins@apollomd.com

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69. Apollo employs individuals at most, if not all, of its facilities whose primary role is to obtain physician signatures and attestations on every mid-level chart. Apollo also ensures employee compliance with these requirements by admonishing its healthcare providers that physician countersignatures are required for the mid-level services to be billed, even though there is no such CMS requirement. Worse still, Apollo ensures that its providers comply with Apollo's charting requirements by threatening that failure to do so will affect both individual paychecks (for those who do have outstanding charts) and the entire department's timely pay. The following September 26, 2013 email from Mr. Dawson is an example of such threats:

From: **Dawson, Adrian** ADRIAN.DAWSON@tenethealth.com
Subject: Month end closing
Date: September 26, 2013 at 12:34 PM
To: Alice Fray amfray@aol.com, Boykin Robinson brobinson@apollomd.com, Camille Miller cam79miller@gmail.com, Charles Chandler chrlschandler@yahoo.com, Chionesu Sonyika drsonyika@yahoo.com, Denis Kim denisjkim@yahoo.com, Fun Fong fun.fong.jr@gmail.com, Jennifer Host jhostmd@gmail.com, Lynn Flowers lflowers@apollomd.com, Marlon Fisher mfisher6@hotmail.com, Mike Webb mwebbkay@aol.com, Richisa Johnson-Hamilton richisa@aol.com, Robert Cox rjcox01@aol.com, Robert Hull rhullmd@yahoo.com, Shannon Howell showell727@yahoo.com, Swetang Desai spd4977@yahoo.com, Theltonia Howard thelhoward@yahoo.com, Tony Polk tonepolk@yahoo.com, Trushnaa Patel tpatel27@gmail.com, Wesley Leigh wesleyleigh@aol.com, Chris Pitts chrispittspac@hotmail.com, Dawn Adams daadams66@comcast.net, Kacie Jones kacieleigh1@aol.com, Leimbach, Jennifer jennifer.leimbach@lmunet.edu, Pohl, Melanie unvmel12@hotmail.com, Pryor, Anita anitapryor@att.net, Satchell, Tiffany tsatchellpac@gmail.com, Scott Anderson seapac65@yahoo.com, Short, Dennis shrtdnns@aol.com, Stephanie Jackson stephanieb.jackson@yahoo.com, Tonya Ogletree tonyaogletree@gmail.com, Young, Daniel1 danyoungpac@gmail.com

Good afternoon, everyone. I was on a conference call this morning with the Group Coordinator supervisors and Roger Murray, ApolloMD's COO. They all stressed that this month-end closing will be particularly tight due to the way the dates fall. Your paychecks as well as everyone else's in the company directly relate to how much money is brought in, which is directly tied to charting. Therefore, it is ***extremely*** important that we get all September charts completed and coded as soon as possible, and EVERY chart should be complete before next Wednesday, October 2nd, so the coders have time to code them. Please check your message center and saved documents before you leave each shift, and complete any lists I give you the day I give them to you. Most of you are very good about this, and I appreciate it! For those of you with longer lists, please work on completing them NOW so the coders are not deluged at the last minute, and work to keep your charts current between now and the end of the month.

Thank you,
Adrian Dawson
ApolloMD Group Coordinator
Spalding Regional Hospital
601 S. 8th St
Griffin, Georgia 30224
Office: 770.228.2721, x2150
Fax: 770.467.6138
adrian.dawson@tenethealth.com

70. Apollo has employed this company-wide scheme despite *knowing* that the Scheme violates CMS requirements and results in the submission of false claims for overpayment to CMS. Apollo sent documents prepared by its "coding partners" to Apollo employees as early as May 2011 explaining that submitting mid-level charts for reimbursement at the full physician rate was prohibited by CMS absent an actual face-to-face patient encounter by the physician. *See* Exhibit 4 attached hereto. These documents establish that Apollo is fully aware of the facts that: (i) "A medical record should clearly identify the provider of the services rendered for it to be reimbursable"; and (ii) a mid-level "visit must be billed out under the name and number of the NPP [non-physician provider, or mid-level] and be reimbursed at 85% of the physician fee schedule." *Id.*

71. Despite its knowledge of CMS regulations, Apollo has implemented a detailed Scheme that wholly ignores and contradicts the CMS requirements. Accordingly, it is apparent that Apollo has willfully designed and perpetrated the Scheme with full knowledge of the Scheme's unlawfulness. Thus, each fraudulent claim for mid-level services Apollo has submitted to CMS has been submitted with the requisite mental state under the FCA. *See* 31 U.S.C. § 3729.

72. Apollo also submits these false claims to CMS and state payers with knowledge of the falsity of the underlying EMRs (*i.e.*, knowledge that a split/shared visit did not truly occur despite the physician attestations and signatures on the EMRs) and the falsity of the resulting claims for reimbursement at the full physician rate for services *never* provided by a physician. At the very least, Apollo submits such claims with reckless disregard for the truth or falsity of the information upon which the claims are made.

73. Apollo systematically perpetrates the Scheme nationwide. Relator observed the exact same policies regarding mid-level charting and physician countersignatures at the two Apollo emergency departments where he has worked for the past six years. Additionally, the uniformity of Apollo's information systems, procedures, policies, training, and communications confirms that the Scheme is not an isolated occurrence, but is embedded in Apollo's business model. Again, the email wherein Apollo's executives essentially admit to the Scheme was sent to *all Apollo physicians* and *came from executives at the corporate headquarters in Atlanta. See* Exhibits 1 & 2. And, Relator's own payment history, discussed *infra*, also proves the systemic nature of the Scheme, as it establishes that Apollo pays Relator a kickback for every mid-level chart he signs, even when he never treated the mid-level's patient. The kickback money is derived from the ill-gotten proceeds Apollo obtained from billing CMS for the mid-level's services under Relator's NPI. *See* Exhibit 5 attached hereto.

74. Apollo's Scheme violates CMS regulations governing reimbursement for E/M services performed by mid-levels and thus the FCA.

C. PAYMENT OF KICKBACKS TO FURTHER THE SCHEME

75. Apollo perpetrates its Scheme in part by offering and paying its physicians a kickback to falsify patient charts so that Apollo can overbill Medicare for services at the physician rate. Indeed, Apollo clearly states that each physician's pay is directly tied to the number of mid-level charts signed and attested to by each physician.

76. The internal employee payment portal at ApolloMD.net demonstrates that physicians are paid a kickback for the mid-level charts they sign. Relator's own payment history directly reflects payments for mid-level encounters that he had no involvement in. *See* Exhibit 5. Though Apollo labels these payments as being for patient visits involving both the physician and

a mid-level (MLP or PA), in reality, the physician had no involvement in the encounter at all. In fact, Relator estimates that 99% of the time, Apollo physicians sign mid-level charts at the end of their shifts, long after most of the patients have already been discharged. Thus, it would be impossible for the physician to have seen the patient with the mid-level provider. Yet, each month, Apollo physicians are paid for every mid-level chart they sign. That has been the case since Relator started working for Apollo in 2010. Indeed, Relator has been compensated for 429 mid-level encounters in a single month for simply signing the mid-level charts assigned to him—a kickback that totaled $18,463. In the chart below (from Relator's internal employee payment portal for Apollo's Spalding Regional Medical Center), this is shown in the column labeled "Pts w/ MLP," which means "Patients with Mid-Level Provider," and in the column labeled "$ Generated MLP Patients," which accounts for the money Apollo paid Relator for signing mid-level charts (though Relator did not actually see any of the patients with a mid-level):

Facility	Payroll Period	Pts Dr Only	Pts w/ MLP	Pts Total	% Current MOS Pts	Current MOS Pts/Hour	Dr Hours Worked	Pts/Dr Hour, Dr Only	Pts/Dr Hour, Total (Incl MLP)	$ Generated Dr Only Pts	$ Generated MLP Patients	$ Generated Total
Spalding Regional Medical Center	7/1/16	321	274	595	97.8%	4.23	137.50	2.33	4.33	$22,158	$12,632	$34,790
Spalding Regional Medical Center	6/1/16	286	244	530	99.8%	4.11	128.50	2.23	4.12	$18,778	$10,603	$29,381
Spalding Regional Medical Center	5/1/16	305	237	542	96.5%	4.32	121.00	2.52	4.48	$20,330	$10,052	$30,381
Spalding Regional Medical Center	4/1/16	372	314	686	99.0%	4.28	158.50	2.35	4.33	$25,673	$13,926	$39,599
Spalding Regional Medical Center	3/1/16	381	351	732	99.9%	4.40	166.00	2.30	4.41	$26,141	$15,979	$42,120
Spalding Regional Medical Center	2/1/16	392	357	749	99.3%	4.65	160.00	2.45	4.68	$26,230	$15,723	$41,953
Spalding Regional Medical Center	1/1/16	382	429	811	97.2%	4.92	160.00	2.39	5.07	$26,288	$18,463	$44,752

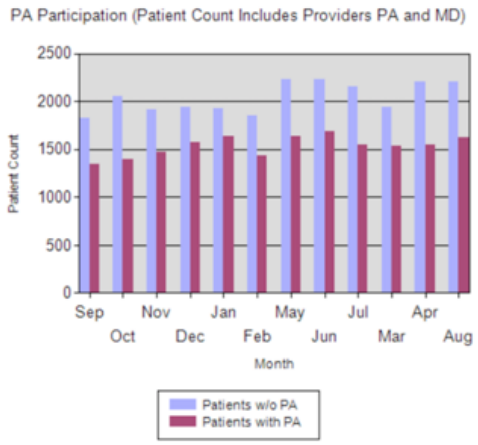
See Exhibit 5. Each month, Relator is credited with treating patients that were actually seen by a mid-level. Relator did not see, nor simultaneously consult with the mid-levels regarding, any of these patients.

77. The same is true for the graphical depiction below, which falsely shows that Relator treated patients with mid-levels at Apollo's Atlanta Medical Center-South:

All Sonyika, Chionesu All

Generated on 8/19/2016 11:10 AM

Hospital	Month	Year	Patients Dr. Only	Patients w/Mid-Level	Patients Total
AMC South	Sep	2010	1	0	1
AMC South	Oct	2010	161	17	178
AMC South	Nov	2010	92	32	124
AMC South	Dec	2010	50	24	74
AMC South	Jan	2011	73	16	89
AMC South	Feb	2011	50	34	84
AMC South	May	2011	90	54	144
AMC South	Jun	2011	35	28	63
AMC South	Jul	2011	35	21	56
AMC South	Sep	2011	18	9	27
AMC South	Oct	2011	68	35	103
AMC South	Nov	2011	58	23	81
AMC South	Dec	2011	74	38	112
AMC South	Jan	2012	123	80	203
AMC South	Feb	2012	95	62	157
AMC South	Mar	2012	173	117	290
AMC South	Apr	2012	169	68	237
AMC South	May	2012	197	117	314
AMC South	Jun	2012	219	97	316
AMC South	Jul	2012	145	87	232



See Exhibit 6 attached hereto. In reality, Relator did not treat or see these patients with a mid-level; instead, Apollo simply required Relator to sign and attest to the charts prepared by mid-levels.

78. As Relator's payment history demonstrates, Relator was paid a portion of the revenue Apollo fraudulently received from CMS, and Apollo directly ties its independent contractor physicians' compensation to the volume of mid-level charts the physicians sign. This *quid pro quo* is a textbook kickback, which the federal Anti-Kickback Statute ("AKS"), 42 U.S.C. § 1320a-7b(b), prohibits.

79. Apollo is inducing physicians to order services reimbursed by Medicare—namely physician E/M services—that are not actually occurring in the vast majority of cases. Accordingly, in addition to flouting the FCA, Apollo's Scheme violates the AKS.

VI. CAUSES OF ACTION

Count One: Violations of the Federal False Claims Act, 31 U.S.C. § 3729(a)(1)(A)

80. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

81. The FCA, 31 U.S.C. § 3729(a)(1)(A) imposes liability upon those who knowingly present or cause to be presented false claims for payment or approval to the United States government.

82. When the submission of such false claims is discovered by a private citizen, the FCA allows the citizen to bring an action on behalf of the United States against the perpetrators. 31 U.S.C. § 3730(b)(1).

83. Through their conduct, Defendants have knowingly presented, or caused to be presented, false claims for payment, as set forth above, in violation of 31 U.S.C. § 3729(a)(1)(A). Specifically, Defendants have submitted false claims for reimbursement for evaluation and management services performed solely by mid-level practitioners in Apollo emergency departments as if they were performed by or in conjunction with a physician.

84. Relator has brought this action pursuant to 31 U.S.C. § 3730(b)(1) and provided a Disclosure Statement to the United States in compliance with § 3730(b)(2).

85. By reason of Defendants' actions, the United States has incurred and continues to incur damages.

Count Two: Violations of the Federal False Claims Act, 31 U.S.C. § 3729(a)(1)(B)

86. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

87. Section 3729(a)(1)(B) of the FCA imposes liability upon those who make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim to the United States government. *See* 31 U.S.C. § 3729(a)(1)(B).

88. Defendants have made, used, or caused to be made or used, false records or statements on medical charts and records regarding the provider of medical services by requiring physicians to sign and attest to mid-level charts for which physicians provided no face-to-face medical treatment and using the falsified charts and records to support claims to CMS for reimbursement at the full physician rate, as if a physician—rather than a mid-level—provided the services. As such, through their conduct, Defendants have made, used, or caused to be made or used, false records or statements material to false or fraudulent claims, as set forth above, in violation of 31 U.S.C. § 3729(a)(1)(B).

89. By reason of Defendants' actions, the United States has incurred and continues to incur damages.

Count Three: Violations of the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b

90. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

91. Section 1320a-7b(b) of the Social Security Act makes it illegal to knowingly and willfully offer or pay 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 to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or 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. Violation of the AKS is a felony punishable by fines and imprisonment, and can also result in exclusion from participation in federal health care programs. 42 U.S.C. §§ 1320a-7(b)(2), 1320a-7(b)(7).

92. In addition, "a claim that includes items or services resulting from a violation of [the AKS] constitutes a false or fraudulent claim for the purposes" of the FCA." 42 U.S.C. § 1320a-7b(g).

93. Through their conduct, Defendants have knowingly and willfully offered and paid kickbacks to contracted physicians and mid-level providers to induce their ordering of non-existent and/or medically unnecessary emergency department services and procedures by directly tying physicians' compensation to the volume of mid-level charts physicians sign each month.

94. As set forth above, Defendants offer and pay these kickbacks in exchange for physician signatures and attestations on mid-level charts in violation of the AKS. Defendants submit such false charts to CMS for reimbursement under the physician's—rather than the mid-level's—NPI so that Defendants may fraudulently obtain reimbursement for the mid-level services provided at the full physician reimbursement rate.

95. None of the statutory or regulatory safe harbors apply to Defendants' conduct.

96. Because this violation of the Anti-Kickback Statute involves a claim for reimbursement to a federal health care program, and that violation is material to the government's reimbursement decision, Defendants' have submitted false claims for reimbursement that include items or services resulting from a violation of the AKS, which constitute false claims under the FCA. *See* 42 U.S.C. § 1320a-7b(g).

97. By reason of Defendants' actions, the United States has incurred and continues to incur damages.

Count Four: Florida False Claims Act,
FL. STAT. § 68.081 *et seq.*

98. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

99. Florida statutes enable the Agency for Health Care Administration to establish the maximum allowable fee for providers through Medicaid rules, policy manuals and handbooks. Fl. Stat. §§ 409.901(2), 409.908. Similar to Medicare, the Florida Agency rules allow for reimbursement for PA services and NP services at a rate below the physician rate, specifically at eighty percent (80%) of the physician rate. Florida Medicaid Practitioner Services Coverage and Limitations Handbook (April 2014), Ch. 3, § 3-6.

100. The Florida False Claims Act imposes liability upon those who knowingly present or cause to be presented a false or fraudulent claim for payment or approval and those who knowingly make, use, or cause to be made or used a false record or statement material to a false or fraudulent claim. Fl. Stat. § 68.082(2).

101. Through their conduct, Defendants have knowingly presented or caused to be presented false or fraudulent claims for approval, as set forth above, to the Florida Medicaid system in violation of Florida Statute § 68.082(2).

102. Through their conduct, Defendants have also knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims, as set forth above, in violation of Florida Statute § 68.082(2).

103. Relator brings this action in accordance with the civil action provision in Florida Statute § 68.083(2) and has complied with all requirements therein.

104. By reason of Defendants' actions, the State of Florida has incurred and continues to incur damages.

Count Five: Georgia State False Medicaid Claims Act, GA. CODE § 49-4-168

105. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

106. Similar to Medicare, Georgia Medicaid rules limit reimbursement for services provided by a PA to no more than 90% of the maximum allowable amount paid to a physician. *See* Georgia Department of Community Health, Division of Medicaid, Policies and Procedures for Physician Services Handbook Ch. 1001.

107. The Georgia State False Medicaid Claims Act imposes liability upon those who knowingly present or cause to be presented to the Georgia Medicaid program a false or fraudulent claim for payment or approval and those who knowingly make, use, or cause to be made or used a false record or statement material to a false or fraudulent claim to the Georgia Medicaid program. Ga. Code § 49-4-168.

108. Through their conduct, Defendants have knowingly presented or caused to be presented to the Georgia Medicaid program false or fraudulent claims for payment or approval, as set forth above, in violation of Georgia Code § 49-4-168.

109. Through their conduct, Defendants have also knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims submitted to the Georgia Medicaid program, as set forth above, in violation of Georgia Code § 49-4-168.

110. Relator asserts this claim in accordance with the civil action provision in Georgia Code § 49-4-168.2 and has complied with all requirements therein.

111. By reason of the Defendants' actions, the State of Georgia has incurred and continues to incur damages.

Count Six: Indiana Medicaid False Claims and Whistleblower Protection Act, IND. CODE § 5-11-5.7-1 *et seq.*

112. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

113. Similar to Medicare, the Indiana Medicaid rules allow for reimbursement of services provided by NPs at a rate below the physician's rate, specifically at seventy-five percent (75%) of the physician rate on file. Indiana Health Coverage Programs BR 200422 (June 1, 2004).

114. The Indiana Medicaid False Claims and Whistleblower Protection Act imposes liability upon those who knowingly present, or cause to be presented, a false claim to the State of Indiana for payment or approval and those who make, use, or cause to be made or used, a false record or statement that is material to a false or fraudulent claim. Ind. Code § 5-11-5.7-2.

115. Through their conduct, Defendants have knowingly presented, or caused to be presented, false claims to the State of Indiana for payment or approval, as set forth above, in violation of Indiana Code § 5-11-5.7-2.

116. Through their conduct, Defendants have also made, used, or caused to be made or used, false records or statements that are material to false or fraudulent claims submitted to the State of Indiana for payment or approval, as set forth above, in violation of Indiana Code § 5-11-5.7-2.

117. Relator asserts this claim in accordance with the civil action provision in Indiana Code § 5-11-5.7-4 and has complied with all requirements therein.

118. By reason of Defendants' actions, the State of Indiana has incurred and continues to incur damages.

Count Seven: Iowa False Claims Act
IOWA CODE §§ 685.1 *et seq.*

119. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

120. Similar to Medicare, Iowa Medicaid rules allow for reimbursement for services performed by mid-levels at a rate below the physician rate, specifically at no more than 85% of the physician fee schedule.[26]

121. The Iowa False Claims Act imposes liability upon those who knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval and those who knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim. Iowa Code § 685.2(1).

122. Through their conduct, Defendants have knowingly presented, or caused to be presented, false or fraudulent claims for payment or approval from the Iowa Medicaid program, as set forth above, in violation of Iowa Code § 685.2(1)(a).

123. Through their conduct, Defendants have knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims for payment or approval under the Iowa Medicaid program, as set forth above, in violation of Iowa Code § 685.2(1)(b).

124. Relator brings this action in accordance with the civil action *qui tam* provision in Iowa Code § 685.3 and has complied with all requirements therein.

125. By reason of Defendants' actions, the State of Iowa has incurred and continues to incur damages.

[26] *See* Iowa Dep't of Human Services, Iowa Medicaid Fee Schedule Factor Code Explanation, http://dhs.iowa.gov/sites/default/files/FactorCodeExplanation.pdf.

Count Eight: Tennessee Medicaid False Claims Act,
TENN. CODE ANN. § 71-5-181 *et seq*.

126. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

127. Similar to Medicare, Tennessee Medicaid rules allow for reimbursement for services performed by a PA at a rate below the physician rate, specifically at no more than sixty percent (60%) of the charges provided for licensed physicians. Tenn. Code Ann. § 71-5-129.

128. The Tennessee Medicaid False Claims Act imposes liability upon those who knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval under the Medicaid program and those who knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim under the Medicaid program. Tenn. Code Ann. § 71-5-182.

129. Through their conduct, Defendants have knowingly presented, or caused to be presented, false or fraudulent claims for payment or approval under the Tennessee Medicaid program, as set forth above, in violation of Tennessee Code § 71-5-182.

130. Through their conduct, Defendants have also knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims submitted under the Tennessee Medicaid program, as set forth above, in violation of Tennessee Code § 71-5-182.

131. Relator brings this action in accordance with the civil action *qui tam* provision in Tennessee Code § 71-5-183 and has complied with all requirements therein.

132. By reason of Defendants' actions, the State of Tennessee has incurred and continues to incur damages.

Count Nine: Texas Medicaid Fraud Prevention Act,
TEX. HUM. RES. CODE § 36.002 *et seq.*

133. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

134. Similar to Medicare, Texas Medicaid rules allow for reimbursement for services provided by a mid-levels at a rate below the physician rate, specifically at ninety-two percent (92%) of the reimbursement for the same professional service paid to a physician. Tex. Admin. Code tit. 1, §§ 355.8093, 355.8281.

135. The Texas Medicaid Fraud Prevention Act imposes liability upon those who: (1) knowingly make or cause to be made a false statement or misrepresentation of a material fact to permit a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized, and (2) knowingly conceal or fail to disclose information that permits a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized. Tex. Hum. Res. Code § 36.002.

136. Through their conduct, Defendants have (1) knowingly made or caused to be made false statements or misrepresentation of material fact in order to receive payment under the Texas Medicaid program that is not authorized, and/or (2) knowingly concealed or failed to disclose information to receive payment under the Texas Medicaid program that is not authorized, as set forth above, in violation of Texas Human Resources Code § 36.002.

137. Relator brings this action in accordance with the civil action *qui tam* provision in Texas Human Resources Code § 36.101 and has complied with all requirements therein.

138. By reason of Defendants' actions, the State of Texas has incurred and continues to incur damages.

VII. DEMAND FOR JURY TRIAL

139. Relator expressly demands a trial by jury.

VIII. PRAYER FOR RELIEF

WHEREFORE, Relator, on behalf of himself, the United States and the Plaintiff States, request that this Court:

(a) Enter judgment that Defendants be ordered to cease and desist from submitting and/or causing the submission of additional false claims or otherwise violating 31 U.S.C. §§ 3729-3733;

(b) Enter judgment against each Defendant in an amount equal to three times the damages the United States has sustained as a result of each and all of Defendants' actions, as well as a civil penalty against each Defendant of $11,000 for each violation of 31 U.S.C. § 3729;

(c) Find joint and several liability against Defendants pursuant to 31 U.S.C. § 3729;

(d) Enter judgment that Defendants be ordered to cease and desist from submitting and/or causing the submission of additional false claims violating the statutes of the respective Plaintiff States as pled herein;

(e) Enter judgment against each Defendant in an amount equal to three times the damages the respective Plaintiff States have sustained as a result of each and all Defendants' actions, as well as a civil penalty against each Defendant in the maximum amount allowable under the statutes of each respective Plaintiff State for each and every false record, statement, certification and claim submitted to the respective Plaintiff States;

(f) Award Relator the maximum amount allowed pursuant to 31 U.S.C. § 3730(d) and the relevant provisions of the statutes of each of the Plaintiff States;

(g) Award Relator all costs and expenses of this action, including court costs, expert fees, and all attorneys' fees incurred by Relator in prosecution of this action; and

(h) Grant the United States, the Plaintiff States and Relator each any further relief as the Court deems just and proper.

Respectfully submitted,

s/Seth Miles
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