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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA, Plaintiff, -against- THE CITY OF NEW YORK, Defendant.	16 Civ. 3280 **COMPLAINT**

The United States of America ("United States" or "Government"), by its attorney, Preet Bharara, United States Attorney for the Southern District of New York, hereby alleges as follows:

INTRODUCTION

1. This is a civil fraud action brought by the United States against the City of New York ("Defendant" or "City"), under the False Claims Act, 31 U.S.C. §§ 3729 *et seq.*, to recover damages sustained by, and penalties owed to, the United States as the result of the Defendant having knowingly and improperly avoided or decreased an obligation to pay or transmit money or property to the Government.

2. Specifically, between October 2008 and October 2012, the City consistently received reimbursements from Medicare for tens of thousands of claims submitted to Medicare for emergency ambulance services that the City had identified in the claims as not meeting the Medicare medical necessity requirement. The City was aware that Medicare was paying reimbursements for these claims, but did not take steps to inform Medicare of the reimbursements for more than four years.

3. As a result, the United States Department of Health and Human Services ("HHS") sustained millions of dollars in losses based upon reimbursements that never should have been issued.

JURISDICTION AND VENUE

4. This Court has jurisdiction over the claim in this action pursuant to 31 U.S.C. § 3730(a) and 28 U.S.C §§ 1331 and 1345.

5. Venue lies in this District pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391(c), because the Defendant is located within this District.

PARTIES

6. Plaintiff is the United States of America, on behalf of the Office of Inspector General of HHS.

7. Defendant is the City of New York, a municipality organized and existing under and by virtue of the laws of the State of New York. The New York City Fire Department ("FDNY") is an agency of the City.

FACTS

I. Applicable Statutes and Regulations

A. The Medicare Program

8. The United States, through HHS, administers the Supplementary Medical Insurance Program for the Aged and Disabled established by Part B, Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* ("Medicare").

9. Part B of Medicare is a federally subsidized health insurance system for disabled persons or persons who are 65 or older. Eligible persons aged 65 and older may enroll in Part B of Medicare to obtain benefits in return for payments of monthly premiums as established by HHS. The benefits covered by Part B of Medicare include medical treatment and services by physicians and suppliers. 42 U.S.C. § 1395k(a)(2)(B).

10. Medical services provided by suppliers are reimbursable under Part B of Medicare if the services provided are reasonable and medically necessary. Reimbursement for Medicare claims is made by the United States through HHS.

11. Medicare Part B provides payment for ambulance services only if such services meet a medical necessity requirement. 42 U.S.C. § 1395x(s)(7). The statute provides that ambulance transportation is covered "where the use of other methods of transportation is contraindicated by the individual's condition . . . ." (the "Medicare medical necessity requirement"). *Id.*

B. The False Claims Act and the Patient Protection and Affordable Care Act

12. The False Claims Act, 31 U.S.C. § 3729 *et seq.* ("FCA"), reflects Congress's objective to "enhance the Government's ability to recover losses as a result of fraud against the Government." S. Rep. No. 99-345, at 1 (1986), *available at* 1986 U.S.C.C.A.N. 5266. As

relevant here, the FCA establishes civil penalties and treble damages liability to the United States for an individual or entity that:

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

31 U.S.C. § 3729(a)(1)(G).

13. "Knowing," within the meaning of the FCA, is defined to include reckless disregard and deliberate indifference to the truth or falsity of the information. *Id*. § 3729(b)(1). And an "obligation," under the statute, includes the "retention of any overpayment." *Id.* § 3729(b)(3).

14. Section 6402(a) of the Patient Protection and Affordable Care Act of 2010 (Enhanced Medicare and Medicaid Program Integrity Provisions), Pub. L. No. 111-148, 124 Stat. 119, 753-56 (2010), amended the Social Security Act by adding a new provision that addresses what constitutes an overpayment under the FCA in the context of a federal health care program. Under this section, an overpayment is defined as "any funds that a person receives or retains under Title XVIII or XIX to which the person, after applicable reconciliation, is not entitled." *See* 42 U.S.C. § 1320a–7k(d)(4)(B). In addition, this provision specifies in relevant part that an "overpayment must be reported and returned" within "60 days after the date on which the overpayment was identified." *Id.* § 1320a–7k(d)(2).

15. Knowing failure to return any overpayment, such as the claims for which the City received an overpayment from Medicare, constitutes a reverse false claim actionable under section 3729(a)(1)(G) of the FCA. Under the FCA, the Government is entitled to recover three times the amount of each claim and, for each claim or overpayment, a civil penalty of not less than $5,500 and not more than $11,000.

II. The City's Receipt of Medicare Reimbursements for Ambulance Services That Did Not Meet the Medicare Medical Necessity Requirement

16. The FDNY provides emergency ambulance services throughout the City, including to individuals eligible to receive benefits through Medicare. FDNY ambulances are dispatched in response to 9-1-1 calls for emergency medical assistance.

17. At all relevant times, including but not limited to October 2008 through and including October 2012 (the "Covered Time Period"), emergency ambulance services for patients eligible for Medicare were only reimbursable from Medicare if those services met the Medicare medical necessity requirement.

18. To receive payment for emergency ambulance services provided to Medicare beneficiaries, the FDNY, through its ambulance billing contractor, submitted claims to Medicare for reimbursement.

19. Each claim for reimbursement contained certain required information about the emergency ambulance services associated with the claim, including information as to whether the FDNY believed that the services met the Medicare medical necessity requirement.

20. During the Covered Time Period, to assess whether emergency ambulance services satisfied the Medicare medical necessity requirement, the FDNY used a computer algorithm to analyze paperwork prepared by FDNY personnel. Based on the results generated by the algorithm, the FDNY indicated in the claim information submitted for Medicare reimbursement whether the emergency ambulance services in question met the Medicare medical necessity requirement.

21. During the Covered Time Period, the FDNY determined that tens of thousands of claims for emergency ambulance services that were submitted to Medicare for reimbursement did not satisfy the Medicare medical necessity requirement, and provided information in the

claims reflecting that determination to National Government Services ("NGS"), a Medicare Administrative Contractor, as part of the claim submission process.

22. During the Covered Time Period, the FDNY consistently received reimbursements from Medicare for the tens of thousands of claims submitted to Medicare for emergency ambulance services that FDNY had identified in the claims as not meeting the Medicare medical necessity requirement.

23. The FDNY was aware that Medicare was paying reimbursements to the FDNY for these claims.

24. Throughout the Covered Time Period, the FDNY received monthly reports from its ambulance billing contractor detailing the status of reimbursement collections, denials, and other relevant billing statistics. The information in these reports was organized by payor, with separate files created for each private insurance carrier and each Government payor, including Medicare.

25. The FDNY's ambulance billing contractor regularly met with FDNY personnel to discuss these reports and issues pertaining to reimbursement for emergency ambulance services.

26. In May 2010, FDNY personnel specifically inquired with the ambulance billing contractor about whether claims for reimbursement were being denied on the basis that the emergency ambulance services did not meet the Medicare medical necessity requirement.

27. In 2010, the FDNY, through its ambulance billing contractor, submitted to Medicare more than 76,000 claims for reimbursement for emergency ambulance services. Of these, more than 12,000 claims—an average of more than 1,000 per month—were identified by the FDNY as not meeting the Medicare medical necessity requirement.

28. Yet in June 2010, in response to the FDNY's May 2010 inquiry, the ambulance billing contractor informed the FDNY that upon reviewing data for a period of several months, the contractor identified only one claim for which Medicare had denied reimbursement on the ground that the services did not meet the Medicare medical necessity requirement.

29. The FDNY did not take steps to inform Medicare of its receipt of reimbursements for the tens of thousands of claims during the Covered Time Period for which it had indicated that the emergency ambulance services did not meet the Medicare medical necessity requirement until December 2012.

30. On or about December 6, 2012, the FDNY sent a letter to NGS and the United States Attorney's Office for the Southern District of New York, reporting, among other things, that the FDNY had been receiving reimbursements for claims for emergency ambulance services that FDNY had identified in the claims as not meeting the Medicare medical necessity requirement. The letter sought guidance regarding the submission of such claims going forward and obligations as to claims previously submitted, and noted that the FDNY was suspending submission of claims for services that may not meet the Medicare medical necessity requirement.

31. In or around September 2013, the FDNY modified its claiming procedures to reduce the risk that the FDNY would be improperly reimbursed for claims for emergency ambulance services that did not satisfy the Medicare medical necessity requirement.

CLAIM FOR RELIEF
(Violation of 31 U.S.C. § 3729(a)(1)(G))

32. The Government incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

33. Defendant knowingly concealed, avoided, or decreased an obligation to pay or transmit money to the United States.

34. Such knowing concealment, avoidance or decrease of an obligation to pay or transmit money to the United States was made or done knowingly, as defined in 31 U.S.C. § 3729(a)(1).

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

(a) treble the United States' damages, in an amount to be determined at trial, plus an $11,000 penalty for each overpayment retained in violation of the FCA;

(b) an award of costs pursuant to 31 U.S.C. § 3729(a)(3); and

(c) such further relief as is proper.

Dated: New York, New York
May 3, 2016

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