UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES and STATE OF NEW YORK ex rel. XIOMARY ORTIZ and JOSEPH GASTON,

Plaintiffs,

-against-

MOUNT SINAI HOSPITAL, MOUNT SINAI SCHOOL OF MEDICINE, and MOUNT SINAI RADIOLOGY ASSOCIATES,

Defendants.

13 Civ. 4735 (RMB)

DECISION & ORDER

I. Background

On November 6, 2014, Xiomary Ortiz and Joseph Gaston ("Plaintiffs" or "Relators") filed an Amended Complaint under the qui tam provisions of the False Claims Act, 31 U.S.C. §§ 3729 et seq. ("FCA") and the New York State False Claims Act, N.Y. State Finance Law §§ 187 et seq. ("NYSFCA") against Mount Sinai Hospital ("MSH" or "Hospital") and two of its affiliates, Mount Sinai School of Medicine ("MSSM" or "School of Medicine") and Mount Sinai Radiology Associates ("MSRA" or "Radiology Associates") (collectively, "Defendants"). (Am. Compl., dated Nov. 6, 2014 ("Compl.") ¶ 1.)[1] Relators contend that Defendants committed "improper billing and wrongful payment retention misconduct . . . against the federal Medicare Program and the New York State Medicaid Program." (Id.) They seek "treble damages, per claim/per false statement penalties, attorneys' fees and litigation expenses, and other relief." (Id.)

[1] On March 5, 2014, after investigating Relators' allegations, both the United States Government and the State of New York declined to intervene in this action. (Docket No. 5.)

Relator Gaston was employed as a "Patient Coordinator" by Radiology Associates from 2001 to 2007, and is currently employed as a Registrar. (Compl. ¶¶ 12, 64.) Relator Ortiz was also a "Patient Coordinator" for Radiology Associates from 2005 to 2007; from 2007 to the start of 2011, she was employed as a "Financial Specialist" in the Hospital's Radiology Billing Department; and from on or about October 18, 2010 to on or about November 15, 2010, Relator Ortiz assisted the Hospital's "Audit & Compliance Services Department in reviewing . . . claims to Medicare and New York Medicaid for possible fraudulent and improper billing." (Id. ¶ 11.) Relator Ortiz is currently employed by Mount Sinai Faculty Practice Associates as an "Accounts Receivable Billing Coordinator in its billing department." (Id.)

Gaston and Ortiz allege that during their tenure as Patient Coordinators, they "witnessed on a near-daily basis instances where the MSH Radiology Billing Department billed Medicare and Medicaid fraudulently and/or improperly for services purportedly provided by MSRA."[2] (Id. ¶¶ 64, 56–57.) Relators allege that:

> Defendants violated the FCA and the NYFCA by: (a) billing in the name of a physician who did not provide the service and/or was not the referring physician ("doctor swapping"); (b) overstating diagnoses and procedure codes ("upcoding"); (c) billing for services not performed ("phantom billing"); (d) billing twice or more for the same service ("multiple billing"); (e) committing more than one of the foregoing acts simultaneously ("combination misbilling"); and (f) retaining overpayments that were received through improper billing activities and practices ("wrongful retention").

(Id. ¶ 2.) The Complaint provides examples of **each** of these categories of alleged fraud:

> As an example of doctor swapping, the medical record for patient A contains a narrative report of a CT neck with contrast performed by Dr.

---

[2] Medicaid refers to the NY State Medicaid program, which is funded jointly by the City and State of New York and the Federal government through the United States Department of Health and Human Services. (Compl. ¶ 8.)

> Puneet S. Pawha on [redacted] and the report was signed by Dr. Pawha. . . . [A] claim was submitted identifying Dr. Pawha as the physician who performed the service; the claim was rejected on the ground that the physician was not certified/eligible to be paid for the service; the claim was resubmitted falsely identifying Dr. Michael Sacher as the physician who performed the service; and a portion of the claim . . . was subsequently paid by Medicare. . . . In this instance, a biller whited out Dr. Pawha's name, and by cutting and pasting, substituted Dr. Sacher's name on the narrative report.

(Id. ¶ 81 (footnote omitted); see also ¶¶ 82, 95(a)–(d) (other examples of doctor swapping).)

> As an example of upcoding, in the record for patient C, Dr. Wilck wrote a report of a CT of the chest, abdomen, and pelvis without contrast dated [redacted]. The service was billed as a CT scan "with and without contrast," and Medicare paid for it as such, when in fact it should have been billed as a non-contrast CT scan.

(Id. ¶ 84; see also ¶¶ 95(e)–(f) (other examples of upcoding).)

> As an example of phantom billing, the invoice and invoice detail with respect to patient D state that Medicare paid $609.86 for a CT performed on [redacted]. However, the "Patient Exam List," which records all services performed for the patient, shows no services performed for Patient D on that date.

(Id. ¶ 85; see also ¶¶ 95(g)–(h) (other examples of phantom billing).)

> As an example of multiple billing, in the case of patient E, Dr. Law performed an MRI of the brain without contrast on [redacted]; and an MRI of the cervical spine without contrast and an MRI of the thoracic spine without contrast on [redacted]. According to the Patient Exam List and physician reports, these three tests, and only these, were performed on Patient E those two dates. However, Defendants billed Medicare a total of $7,500 for these three tests as if all were performed on [redacted] when in fact only the MRI of the brain was done on [redacted]. Medicare paid defendants for these tests. Defendants also billed Medicare a total of $5,000 for the MRI of the cervical spine and the MRI of the thoracic spine under the date of [redacted], and Medicare paid Defendants for these tests as well. As a result, Defendants double billed Medicare, and Medicare paid double, for the MRI of the cervical spine and for the MRI of the thoracic spine.

(Id. ¶ 86; see also ¶ 95(i) (another example of multiple billing).)

> The [combination misbilling] in the case of patient E is an instance of doctor swapping as well as multiple billing, and is thus an instance of multiple fraud. According to the physician reports, the tests on [redacted] were done by Dr. Law but are falsely recorded in the invoice records as being done by Dr. Delman. Dr. Delman was eligible for payment by Medicare; Dr. Law was not.

(Id. ¶ 87; see also ¶ 88 (another example of combination misbilling).)

And, as an example of wrongful retention:

> Upon information and belief . . . Defendants did not refund any overpayments that were identified by Relator Ortiz, or that should have been identified by Defendants as a result of the information she had provided them, within 60 days of Relator Ortiz' alerts to the MSH Audit & Compliance Services Department employees.

(Id. ¶ 94; see also ¶¶ 89–93 (examples of wrongful retention).)

Relators also contend that they "orally objected to these practices to employees of MSH, including, John W. Hart and Daniel Dorce" (Id. ¶¶ 56, 64) who, "from at least as early as 2001 to approximately 2011 . . . were employed by MSH as directors of the MSH Radiology Billing Department and had managerial responsibilities for operating the department on a daily basis." (Id. ¶ 19.) Relator Gaston was allegedly "reprimanded by [Hart and Dorce] when he tried to ensure that only correct bills were sent out for reimbursement by insurers." (Id. ¶ 106.) "Hart and Dorce told [him] . . . to only bring billing mistakes to their attention if Defendants were going to 'lose money,' otherwise the mistaken bills were to be processed for payment." (Id.)

In 2007, Ortiz, as noted, became a "Financial Specialist" in the MSH Radiology Billing Department, "where, among other things, she was responsible for following up on claims that were rejected by insurance companies." (Id. ¶ 11.) Ortiz "witnessed on a near daily basis" alleged fraudulent billing practices and "objected to these practices" to Hart and Dorce. (Id. ¶ 57.) In September of 2010, Ortiz "reported [by phone] to Marina Lowy, Esq., an attorney in MSH's Legal Department . . . that [Ortiz] was aware of fraudulent billing practices in the MSH Radiology Billing

Department." (Id. ¶ 58.) Oritz says she was told, "in sum and substance, that MSH would investigate [her] allegations and refund any overpayments." (Id. ¶ 58.) "Shortly after [her phone call with Lowy], Ortiz met with the MSH Audit and Compliance Services Department" and "described to them certain fraudulent billing practices she had observed, and/or participated in, at the MSH Radiology Billing Department . . . specifically mention[ing], among other things, that [Dorce] had instructed billing staff employee Leola Silva to physically cut and paste physician signatures onto billing records." (Id. ¶ 59.)

From October of 2010 to November of 2010, "while functioning as a Medicare and Medicaid claims reviewer in the MSH Audit and Compliance Services Department," Ortiz "analyzed approximately 400 randomly selected claims that MSH Radiology Billing Department had submitted on behalf of MSRA to either Medicare or New York Medicaid Programs for reimbursement during the approximate years of 2007-2009." (Id. ¶¶ 60–61.) **Ortiz alleges that she "uncovered [evidence] that approximately 40% of the Medicare claims and 50% of the New York Medicaid claims records she had reviewed were fraudulent or improper."** (Id. ¶ 61) (emphasis added).

"On or about November 3, 2010, Relator Ortiz signed a written statement presented to her and co-signed by MSH Audit & Compliance Department employee Bruce Sackman, which alerted MSH to various types of billing misconduct in the MSH Radiology Billing Department." (Id. ¶ 62.) Sackman "told [Ortiz] after she conveyed her findings to him that MSH Audit & Compliance Services Department employees had conducted an internal investigation . . . ." (Id. ¶ 105.) Sackman also told Ortiz "that MSH employee John W. Hart acknowledge[d] rampant fraud, but blamed it on by then ex-MSH employee Daniel Dorce." (Id.) "Ultimately, MSH . . . instruct[ed] billing staff to immediately stop all improper billing practices, outsource[ed] all billing functions to

a third party vendor, fir[ed] MSH employee Daniel Dorce (purportedly for sexual harassment) and transferr[ed] MSH employee John W. Hart to a non-billing area at MSH." (Id. ¶ 107.)

On December 17, 2014, Defendants filed a motion to dismiss the Complaint pursuant to Rules 12(b)(6) and 9(b) of the Federal Rules of Civil Procedure, arguing, inter alia, that: (1) "Relators may not rely on improperly obtained confidential patient records as the basis for their complaint" (Mem. of Law in Supp. of Defs.' Mot. to Dismiss, dated Dec. 17, 2014 ("Defs.' Mem."), at 4–5); (2) "the underlying [medical treatment] records [some of which Defendants attached to their motion to dismiss] are integral to the complaint and contradict Relators' allegations" (id. at 7); (3) "Relators do not plead fraud with particularity," failed to "plead sufficient details showing specific false claims," failed to specify facts demonstrating "scienter," and improperly alleged wrongful retention "expressly based on 'information and belief'" (id. at 16, 18, 21, 22); (4) "Relators do not state a claim for Medicaid fraud" (id. at 23); and (5) Relators employ "aggregate pleading" and "fail to identify [Defendant(s)] responsible for submitting any of the alleged false claims" (id. at 19).

On January 21, 2015, Relators filed an opposition, arguing, inter alia, that (1) there is no evidence of Relator misconduct relating to patient records and "[the Complaint] says nothing about the circumstances under which Relators obtained any patient medical and billing information" (Relators' Mem. of Law in Opp'n to Defs.' Mot. to Dismiss, dated Jan. 21, 2015 ("Opp."), at 5); (2) the Court should exclude Defendants' extrinsic exhibits and "may consider only the [C]omplaint, any exhibits thereto or incorporated by reference, and matters which may be judicially noticed pursuant to Federal Rule of Evidence 201" (id. at 10); (3) the Complaint "adequately alleges details of specific false claims," "adequately pleads scienter," and "properly relies on 'information and belief' in its 'wrongful retention' theory of liability" to show that "Defendants did not refund any

overpayments that were identified by Relator Ortiz, or that should have been identified by Defendants as a result of the information she provided them . . . ." (id. at 15–19; Compl. ¶ 94); (4) "there are, in fact, at least six specific examples of Medicaid Fraud in the [Complaint]" (id. at 22); and (5) "the Complaint "clearly outlines [all] the Defendants' and their employees' respective roles in the charged False Claims Acts violations" (id. at 18).

On January 30, 2015, Defendants filed a reply, arguing, inter alia, that "this Court is entitled to, and should, take notice of the fact that Relators' allegations are in fact refuted by the very documents upon which they claim to rely." (Reply Mem. of Law in Supp. of Defs.' Mot. to Dismiss, dated Jan. 30, 2015, at 4.) Helpful oral argument was held on June 23, 2015. (See Tr. of Oral Arg., dated June 23, 2015 ("Oral Arg. Tr.").)

For the reasons stated below, Defendants' motion to dismiss is denied.[3]

II. Legal Standard

In considering a motion under Rule 12(b)(6), the Court "is normally required to look only to the allegations on the face of the complaint," Roth v. Jennings, 489 F.3d 499, 509 (2d Cir. 2007), and "must liberally construe all claims, accept all factual allegations in the complaint as true, and draw all reasonable inferences in favor of the plaintiff." U.S. ex rel. Kester v. Novartis Pharm. Corp., No. 11 CIV. 8196 CM, 2015 WL 109934, at *5 (S.D.N.Y. Jan. 6, 2015)[4] (citing Roth, 489 F.3d at 510).

---

[3] **Any issues raised by the parties not specifically addressed herein were considered by the Court and rejected.**

The Court is not here ruling upon the ultimate merits of the parties' respective claims or defenses.

[4] Novartis is a qui tam action under the FCA which has been extensively litigated in this Circuit. The Court cites to a series of orders in Novartis, specifically U.S. ex rel. Kester v. Novartis Pharm. Corp., 23 F.Supp.3d 242 (S.D.N.Y.2014) ("Novartis I"); U.S. ex rel. Kester v. Novartis

"Claims brought under the FCA fall within the express scope of Rule 9(b)." Gold v. Morrison–Knudsen Co., 68 F.3d 1475, 1477 (2d Cir. 1995). "To satisfy the pleading requirements of Rule 9(b), a complaint must '(1) specify the statements that the plaintiff contends were fraudulent, (2) identify the speaker, (3) state where and when the statements were made, and (4) explain why the statements were fraudulent.'" Novartis I, 23 F. Supp. 3d 242, 257 (quoting Wood ex rel. U.S. v. Applied Research Assocs., Inc., 328 Fed. Appx 744, 747 (2d Cir. 2009)). While "there is no mandatory 'checklist' of identifying information that a plaintiff must provide, the complaint must include sufficient details about the false claims such that the defendant can reasonably 'identify [the] particular false claims for payment' that are at issue." Novartis I, 23 F. Supp. 3d 242, 256 (quoting U.S. ex rel. Karvelas v. Melrose-Wakefield Hospital, 360 F.3d 220, 232 (1st Cir. 2004)).

U.S. Courts of Appeals appear to disagree as to what constitutes "particularity" under Rule 9(b) in the context of the FCA. The Third, Fifth, and Ninth Circuits hold "that it is sufficient for a plaintiff to allege 'particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted.'" Foglia v. Renal Ventures Mgmt., LLC, 754 F.3d 153, 156 (3d Cir. 2014); see also Ebeid ex rel. U.S. v. Lungwitz, 616 F.3d 993, 998–99 (9th Cir. 2010); United States ex rel. Grubbs v. Kanneganti, 565 F.3d 180, 190 (5th Cir.2009). The First, Fourth, Sixth, Eighth, and Eleventh Circuits require that "a plaintiff must plead both the particular details of a fraudulent scheme and 'details that identify particular false claims for payment that were submitted to the government.'" Novartis I, 23 F. Supp. 3d at 255 (quoting Karvelas, 360 F.3d at 232); see also United States ex rel. Noah Nathan v. Takeda Pharm. Pharm. Corp., 11 Civ. 8196, 2014 WL 2619014 (S.D.N.Y. June 10, 2014) ("Novartis II"); and U.S. ex rel. Kester v. Novartis Pharm. Corp., No. 11 CIV. 8196 CM, 2015 WL 109934 (S.D.N.Y. Jan. 6, 2015) ("Novartis VII").

N. Am., Inc., 707 F.3d 451, 455–56 (4th Cir. 2013), cert. denied, 134 S. Ct. 1759, 188 L. Ed. 2d 592 (2014); United States ex rel. Bledsoe v. Cmty. Health Sys., Inc., 501 F.3d 493, 510 (6th Cir. 2007); United States ex rel. Joshi v. St. Luke's Hosp., Inc., 441 F.3d 552, 557 (8th Cir. 2006); United States ex rel. Clausen v. Lab. Corp. of Am., Inc., 290 F.3d 1301, 1308, 1312 (11th Cir. 2002). District courts within the Second Circuit have held "that plaintiffs asserting [§ 3729](a)(1)(A) and [§ 3729](a)(1)(B) claims must plead the submission of a false claim with a high degree of particularity." See Novartis I, 23 F. Supp. 3d at 256-57 (collecting cases); but see United States v. Huron Consulting Grp., Inc., No. 09 CIV. 1800 JSR, 2011 WL 253259, at *2 (S.D.N.Y. Jan. 24, 2011).

Where, as here, Relators allege "numerous transactions that occurred over a long period of time, courts have found it impractical to require the plaintiff to plead the specifics with respect to each and every instance of fraudulent conduct." Novartis I, 23 F. Supp. 3d at 258 (citation omitted). Relators "may satisfy Rule 9(b) by providing sufficient identifying information about those false claims, or by providing example false claims that enable the defendant to identify similar claims." Id. at 260.

III. Analysis

(1) It is Premature to Conclude Defendants' Records were Obtained Improperly

Defendants argue that the Complaint "relies extensively upon, and incorporates by reference, various patient and billing records—including physicians' reports, exam schedules, and invoices—that were obtained without authorization from MSSM" and that "Relators should be precluded from using such records to support their claims." (Defs.' Mem. at 4–5.) Relators counter that the only facts "properly before the Court are those alleged in the [Complaint] and it says nothing about the circumstances under which Relators obtained any patient medical and billing information." (Opp. at 5.) Relators further argue that the Health Insurance Portability and

Accountability Act of 1996 ("HIPAA"), Pub. L. No. 104–191, 110 Stat.1936, "carves out an exception that allows 'whistleblowers' to reveal such information to governmental authorities and private counsel, provided that they have a good faith belief their employer engaged in unlawful conduct." (Opp. at 3) (citing 45 C.F.R. 164.502(j)).)

Defendants' request for preclusion of Relator's evidence is premature. See Novartis VII, 2015 WL 109934, at *22 ("[W]ithout evidence [the court] will not assume that relator took 'undisclosed formal discovery' in violation of the Federal Rules of Civil Procedure."). Each of the cases cited by Defendants establish that there must be a factual finding that a party had behaved improperly. (Defs.' Mem. at 5–6 (citing, inter alia, Fayemi v. Hambrecht & Quist, Inc., 174 F.R.D. 319, 321 (S.D.N.Y. 1997) ("A hearing was held on July 2, 1997, and the following findings are based on the evidence presented there."); U.S. ex rel. Rector v. Bon Secours Richmond Health Corp., No. 11-CV-38, 2014 WL 66714 at *5 (E.D. Va. Jan. 6, 2014) ("[A] party must show that misconduct occurred by 'clear and convincing evidence,' as opposed to by a mere preponderance in order for the Court to exercise its inherent power to sanction.")).)

Even assuming, arguendo, that Defendants' request for preclusion is not premature, the Court finds that there is strong public policy in favor of protecting those who report fraud against the government. See U.S. ex rel. Ruhe v. Masimo Corp., 929 F. Supp. 2d 1033, 1039 (C.D. Cal. 2012) (where relators "sought to expose a fraud against the government and limited [obtaining] documents relevant to the alleged fraud . . . this taking and publication was not wrongful, even in light of nondisclosure agreements, given 'the strong public policy in favor of protecting whistleblowers who report fraud against the government.'") (citing U.S. ex rel. Grandeau v. Cancer Treatment Ctrs. of Am., 350 F. Supp. 2d 765, 773 (N.D. Ill. 2004) ("Relator and the government argue that the confidentiality agreement cannot trump the FCA's strong policy of protecting

whistleblowers who report fraud against the government.")). Indeed, Defendants appear to acknowledge that "the FCA 'contemplates whistleblower possession of documents obtained from employers.'" (Defs.' Mem. at 6 (citing Rector, 2014 WL 66714, at *6).)

(2) Defendants' Exhibits

Defendants have attached nearly two dozen exhibits in support of their motion to dismiss. (Decl. of Wendy H. Schwartz, dated December 17, 2014 ("Schwartz Decl.") at ¶¶ 2–24.)[5] Defendants acknowledge that none of their exhibits are attached to the Complaint or (explicitly) incorporated by reference. (Oral Arg. Tr. at 5:1–8 (Ms. Schwartz, counsel for Defendants: "They are not expressly incorporated. . . . Our position is that they are impliedly referenced."); id. at 8:17–22 (Ms. Schwartz: "[Relator] does not claim that she relied upon [the exhibits]. . . . We are asking the Court to make that inference.").) Defendants argue that the exhibits are "documents upon which [the Complaint] rel[ies], or [are] facts of which the court may take judicial notice." (Defs.' Mem. at 6–7)

Relators counter that none of Defendants' exhibits are "attached to, incorporated in, integral to or relied on exclusively" in the Complaint, and that "[m]ost, if not all, require elaboration and even authentication." (Opp. at 11.) They assert that it would be "inappropriate to discredit the

---

[5] Defendants' exhibits include: (1) "various Confidentiality Statement and HIPAA attestations executed by relators as a condition of their employment" (Defs' Mem. at 4–5 (citing Schwartz Decl. at ¶¶ 2–4); (2) medical records of underlying treatments on which Relators are said to base their fraud allegations (Schwartz Decl. at ¶¶ 5–12); (3) physicians' Medicare enrollment letters (id. at ¶¶ 13–16); (4) "a March 3, 2011 voluntary disclosure letter [from the] Chief Compliance Officer for the Mount Sinai Medical Center, to Jack Daniels of the Voluntary Disclosure Program of the New York State Office of the Medicaid Inspector General," and "documents evidencing [Medicare] repayments" (id. at ¶¶ 17–18); (5) a United States Department of Health and Human Services Appeals Board Order, dated March 26, 2014 (id. at ¶ 19); and (6) excerpts from various Medicare manuals and fee schedules, including an explanation of the coding system used (id. at ¶¶ 20–23.) (Opp. at 11.)

factual allegations of a complaint merely because they are contradicted by assertions made" by Defendants. (Id. (citing Roth, 489 F.3d at 511)).

As the Court stated on June 23, 2015, Defendants' "arguments are more in the nature of summary judgment than they are of a motion to dismiss" (Oral Arg. Tr. at 5:12–14) and Defendants are "asking [the Court] . . . to find no liability here based on [Defendants'] documents." (Id. at 5:24–6:1; see Defs.' Mem. at 8–16.)

> [Defendants' motion] appears more like a motion for summary judgment. It appears as if you [Defendants] are trying . . . to prove that your clients are not liable. So, for example, [Defendants have] attached numerous documents, exhibits . . . confidentiality agreements, Medicare enrollment forms, a decision about a doctor's Medicare eligibility, your own accounting records and a voluntary disclosure letter . . . . So all of this is something we would normally see at summary judgment and, again, . . . your very clear opinion is that your clients did nothing wrong. **And I don't know how one in my position gets to appropriately reach that conclusion on a motion to dismiss.**

(Oral Arg. Tr. at 3:25–4:12 (emphasis added).)

The Court has not converted Defendants' motion to dismiss into one for summary judgement and "look[s] only to the allegations on the face of the complaint." Roth, 489 F.3d at 509; see also Kopec v. Coughlin, 922 F.2d 152, 155 (2d Cir. 1991) ("We hold that, since the district court considered affidavits and exhibits submitted by Dr. Scheinfeld in granting the motion to dismiss, it erred in failing to convert the motion to one for summary judgment and failing to permit Kopec an opportunity to controvert those submissions."). Relators are correct that Defendants' documents "require elaboration and even authentication" and that—at this stage of the case—it would be "inappropriate to discredit the factual allegations of a complaint merely because they are contradicted." (Opp. at 11 (citing Roth, 489 F.3d at 511).)

(3) Relators Adequately Plead Fraud Claims

As noted, Relators allege three bases of liability under the FCA, namely, submitting false claims in violation of § 3729(a)(1)(A); using false records to support those false claims in violation of § 3729(a)(1)(B); and avoiding the obligation to refund overpayments to the Government in violation of § 3729(a)(1)(G).[6] (Opp. at 10.) To state a claim under § 3729(a)(1)(A), a relator must allege that: (1) there was a false or fraudulent claim; (2) defendants knew it was false or fraudulent; (3) defendants presented the claim, or caused it to be presented, to the United States; and (4) defendants did so to obtain payment from the Federal treasury. Novartis I, 23 F. Supp.3d at 252 (citing Pervez, 736 F. Supp.2d at 811). Section 3729(a)(1)(B) requires a relator to allege that: (1) defendants made a false or fraudulent record or statement; (2) defendants knew it to be false or fraudulent; and (3) it was material to a claim for reimbursement. Id. (citing Pervez, 736 F. Supp.2d at 811). And, to state a claim under Section 3729(a)(1)(G) for wrongful retention, relators "must show: (1) 'proof that the defendant made a false record or statement' (2) at a time that the defendant had a presently-existing 'obligation' to the government—'a duty to pay money or property.'" Novartis II, 2014 WL 2619014, at *10 (quoting Chesbrough v. VPA, P.C., 655 F.3d 461, 473 (6th Cir. 2011)).[7]

---

[6] Relators state that "for the instant motion, the elements of the FCA and NYS FCA counts as well as their pre-and post-amended versions are substantially the same." (Opp. at 10 n.19.) Defendants do not disagree. See also U.S. ex rel. Pervez v. Beth Israel Med. Ctr., 736 F. Supp.2d 804, 811 n.38, 816 (S.D.N.Y. 2010); U.S. ex rel. Blundell v. Dialysis Clinic, Inc., 09-CV-710 (NAM), 2011 WL 167246 at *21 (N.D.N.Y. Jan. 19, 2011).

[7] Relators' wrongful retention claim applies to conduct which occurred after the 2009 amendments to the FCA in the Fraud Enforcement and Recovery Act of 2009, Pub. Law 111–21, 123 Stat. 1617, 1621–25 (2009), and specifically to "conduct that takes place in the fall of 2010." (Oral Arg. Tr. at 15:14–15.) "[Relators' counsel] Mr. McInnis: [I]n the pre-2009 version [of the FCA], there was not an express cause of action for wrongful retention." (Id. at 14:22–24; see also id. at 13:21–14:5 ("[Defendants' counsel] Ms. Schwartz: Wrongful retention, the law has changed. . . . [B]efore the amendments, the wrongful retention provisions were much less specific than they

Section 3729(a)(1)(A) – False or Fraudulent Claims

Defendants contend that Relators fail to allege the first two elements of their Section 3729(a)(1)(A) claim, i.e., the existence of fraudulent claims and that Defendants knew that the claims were fraudulent. This includes the element of "scienter." (Defs.' Mem. at 18, 21.)[8] Defendants argue that Relators fail to plead "when the alleged false claims that constitute the supposed wrongful scheme were submitted, how they were submitted, who submitted them, the amounts sought or received with respect to each claim, why they were false, and what the appropriate reimbursement amounts should have been," (Defs.' Mem. at 21), and that Relators "fail to specify facts demonstrating scienter," presumably because the "only allegations of scienter are based on an alleged awareness by one employee, Daniel Dorce, of the alleged practice of 'doctor swapping.'" (Defs.' Mem. at 18.) At oral argument, Defendants' counsel, Ms. Schwartz, contended that, "[f]or instance, in Paragraph 96, the Relator says Mr. Dorce asked her to change dates of service on a Medicaid claim," but that "Mr. Dorce's comments "do not connect with any of the specific claims. Mr. Dorce's alleged comments relate to unidentified claims in a scheme that could involve claims that have nothing to do with Medicaid and Medicare." (Oral Arg. Tr. at 11:4–15.)

Relators counter that "Rule 9(b) does not impose a one size fits all list of facts that must be included in every FCA complaint" (Opp. at 16 (quoting U.S. ex rel. Bilotta v. Novartis Pharms. Corp., 2014 U.S. Dist. LEXIS 139072, at *23 (S.D.N.Y. Sept. 30, 2014))), and that the Complaint

---

are now."); id. at 14:7–9 ("The Court: So your argument is whether the law is the pre-2009 versus the post-2009, their claim still fails? Ms. Schwartz: Correct, even as to wrongful retention.").); see also supra n.6.

[8] Defendants do not appear to argue that Relators have failed to allege the third or fourth elements, namely that the claims were presented to the United States and that Defendants sought payment from the U.S. Treasury. (See Defs.' Mem.; Opp. at 10.)

provides sufficient particularity because it alleges "myriad claim-specific details." (Opp. at 18 (citing Compl. ¶¶ 81–88, 95(a)–(i), 96, and 99).) Relators also argue that while "Defendants characterize [Relators' claims] as 'innocuous instances' [that] does not make them any less particularized for Rule 9(b) purposes." (Id.) Relators also argue that the Complaint alleges that there were actual "instructions from billing supervisors Dorce and Hart which leave no doubt that their actions were knowing—even willful" (Opp. at 17), and that Relator Ortiz was given directives to "ignore billing errors if correcting them would cost Defendants money," "'override' the billing system," "bill for services not rendered," and "alter medical records." (Id. (citing Compl. ¶¶ 76, 96–98, 106).) Relators state that the Complaint "quotes or paraphrases supervisors Hart and Dorce telling staff that they were under pressure from administrators to meet strict monthly revenue quotas" (¶ 77), and "describes Dorce admitting that the billing department was 'not 100% compliant' and expressing fear of criminal liability . . . ." (Id. (citing Compl. ¶¶ 77, 97, 100).)

Relators further point out that the Complaint "alleges that Defendants' senior auditor Sackman told Relator Ortiz that he would not take her fraud findings to Medicare and Medicaid, but rather 'would handle it internally.'" (Id. (quoting Compl. ¶ 104).) Relators contend that the Complaint "quotes or paraphrases senior auditor Fuller telling Relator Ortiz that, 'If Medicare was ever to find out about this, we would be screwed.'" (Id. (quoting Compl. ¶ 102).) In addition, during oral argument, Relators' counsel, Mr. McInnis, contended that Relator Ortiz "participated in an internal investigation, and during the course of that, people, representatives from Mount Sinai from the compliance unit, acknowledged that there was wrongdoing," and that because the fraudulent conduct "went [on] a near daily basis for a long period of time . . . [t]hat, alone, could permit the Court to infer intent." (Oral Arg. Tr. at 18:22–24; 18:4–6; 18:20–22.)

Plaintiffs asserting subsection (a)(1)(A) violations "must plead the submission of a false claim with a high degree of particularity." Novartis I, 23 F. Supp. 3d at 25 256–57. "A plaintiff must plead both the particular details of a fraudulent scheme and details that identify particular false claims that were submitted to the government." Id. at 255. While a plaintiff may "[a]dequately plead scienter . . . [by alleging that defendant] *knowingly* causes to be presented a false or fraudulent claim for payment or approval or *knowingly* causes to be made or used, a false record or statement material to a false or fraudulent claim," Bilotta, 50 F. Supp. 3d at 528 (emphasis in original), "scienter . . . may [also] be alleged generally." Novartis I, 23 F. Supp. 3d at 251 (citing Fed. R. Civ. P. 9(b) ("Malice, intent, knowledge, and other conditions of a person's mind may be alleged generally."). In addition, "the FCA's knowledge standard plainly encapsulates recklessness and deliberate ignorance." Kane ex rel. U.S. v. Healthfirst, Inc., No. 11 Civ. 2325 ER, 2015 WL 4619686, at *18 (S.D.N.Y. Aug. 3, 2015).

The Court finds that Relators assert subsection (a)(1)(A) violations with a high degree of specificity by alleging "the particular details of a fraudulent scheme" and "identify[ing] particular false claims for payment that were submitted to the government." See Novartis I, 23 F. Supp. 3d at 255 (quoting Karvelas, 360 F.3d at 232). The level of particularity required "depends upon the nature of the case, the complexity or simplicity of the transaction or occurrence, the relationship of the parties and the determination of how much circumstantial detail is necessary to give notice to the adverse party and enable him to prepare a responsive pleading." Id. (quoting United States v. Wells Fargo Bank, N.A., 972 F. Supp.2d 593, 616 (S.D.N.Y. 2013).[9] The level of detail provided

[9] The particularity requirement, which is met in this case, "serves several aims: 'to provide a defendant with fair notice of a plaintiff's claims, to safeguard a defendant's reputation from improvident charges of wrongdoing, . . . to protect a defendant against the institution of a strike suit,' and to 'discourage[ ] the filing of complaints as a pretext for discovery of unknown wrongs.'"

by Relators in alleging examples of improper billing practices and claims constitutes a "high enough degree of particularity that defendants can reasonably identify particular false claims for payment that were submitted to the government."[10] Novartis I, 23 F. Supp.3d at 258; see also U.S. ex rel. Harris, 275 F. Supp.2d 1, 8 (D.D.C. 2003).

For example, the Complaint alleges, as noted, several instances of "doctor swapping" at paragraphs 81–82 95(a)–(d), and 99, and provides: (a) the date; (b) a description of the medical treatment; (c) the name of the doctor who allegedly performed the treatment; (d) that a claim was submitted to either Medicare or Medicaid identifying the doctor as the treating physician; (e) that the claim was resubmitted after an employee of MSH "whited-out" the first doctor's signature and replaced it with that of another doctor who was eligible to bill Medicare or Medicaid for the service; and (f) that the claim (or part of it) was paid by the Government. (Opp. at 18 (citing Compl. ¶¶ 81–82, 87–88, 95(a)–(d))). "[A] biller whited out Dr. Mitty's name, and by cutting and pasting, substituted Dr. Wilck's name on the narrative report" of the medical record for patient B. (See Compl. ¶ 82.)

The Complaint, as noted, also specifies incidents of "upcoding." In one, "Dr. Wilck wrote a report of a CT of the chest, abdomen, and pelvis without contrast dated [redacted]. The service was billed as a CT scan 'with and without contrast' . . . when in fact it should have been billed as a non-contrast CT scan." (Id. ¶ 84; see also ¶¶ 95(e)–(f).) Relators include the date of the procedure(s),

---

Kane, 2015 WL 4619686, at *7 (quoting Novartis I, 23 F.Supp.3d at 252); see also Wood, 328 F. App'x at 747.

10 That Defendants appear able to identify Relators' claims, is reflected by the fact that they have attached the underlying documents relating to those claims to their motion to dismiss. (Schwartz Decl. ¶¶ 5–12; Oral Arg. Tr. at 9:8–9 ([Defendants' counsel] Ms. Schwartz: "We are on notice of what she's contending, but that's only half of the test.").)

the doctor who conducted the procedure(s), the allegation that a fraudulent claim was submitted, and the reason the claim was fraudulent.

The Complaint, as noted, also specifies instances of "phantom billing."

> As an example of phantom billing, the invoice and invoice detail with respect to patient D state that Medicare paid $609.86 for a CT performed on [redacted]. However, the 'Patient Exam List,' which records all services performed for the patient, show no services performed for Patient D on that date.

(Id. ¶ 85; see also ¶ 95(h).) The Complaint provides the date of the procedure, the procedure performed, the contention that the claim was submitted to Medicare, the amount paid by Medicare, and an explanation of why that claim was fraudulent.

With respect to "multiple billing," Relators allege, as an example, that on a certain date, "a pre-and post-contrast CT angiography of the chest, abdomen, and pelvis was conducted for the patient" and that "Defendants mistakenly billed, and Medicare paid for, only the abdomen and the pelvis." (Id. ¶ 95(i).) When "Defendants subsequently billed for the chest, it [sic] also billed Medicare again for the abdomen and pelvis, and Medicare paid for all of the services billed." (Id.; see also ¶ 86 for another example of multiple billing.) These allegations provide the date of treatment, the nature of the treatment, the claim(s) submitted, and why the claim(s) were fraudulent (i.e. Defendants were reimbursed twice for the abdomen and pelvis CT angiographies). (Id. ¶ 95(i).)

With respect to "combination misbilling," Relators present two examples at ¶¶ 87–88 of their Complaint. Each example identifies the date of treatment, the nature of the treatment, the doctor who performed the treatment, that a claim was submitted to Medicare, and why the claim was fraudulent. (See, e.g., id. ¶ 88 ("Defendants billed, and Medicare paid, for two views of the chest, PA/AP and lateral, when in fact the physician's report, dated . . . shows that only one view,

PA/AP was obtained" (upcoding) and that "report is signed by Dr. Mitty, who was not Medicare eligible, but Defendants submitted a bill that falsely states that services . . . were rendered by Dr. Wilck, who was eligible for payment by Medicare." (doctor swapping)).)

The Court also finds that Relators adequately plead the scienter element of subsection (a)(1)(A) by alleging, with illustrative examples, that Defendants "knowingly cause[d] to be presented a false or fraudulent claim for payment or approval or knowingly cause[d] to be made or used, a false record or statement material to a false or fraudulent claim." See Bilotta, 50 F. Supp. 3d at 528. At the very least, Relators allegations unequivocally satisfy "the FCA's knowledge standard [by] plainly encapsulat[ing] recklessness and deliberate ignorance" by the Defendants. See Kane, 2015 WL 4619686, at *18. For example, Relators allege that they each "orally objected to [the fraudulent billing] to employees of MSH, including, John W. Hart and Daniel Dorce," presumably putting MSH on notice that the billing practices were illegal, yet the fraudulent billing continued. (Compl. ¶¶ 56, 64.) In addition, Relators allege that Dorce "instructed MSH Radiology Billing Department employees and MSRA Front End staff workers, including the Relators" to "bill for services not rendered," and to "alter medical records." Relators also allege that Dorce admitted that the MSH Radiology Billing Department was "not 100% compliant." (Compl. ¶¶ 76, 96–98, 100, 106.) Ortiz, according to Relators' counsel, "participated in an internal investigation, and during the course of that, people, representatives from Mount Sinai in the compliance unit, acknowledged there was wrongdoing." (Oral Arg. Tr. at 18:3–6; see also Compl. ¶¶ 101–05.) Relators also allege that MSH Audit & Compliance Department employee, Bruce Sackman, told Ortiz "that MSH employee John W. Hart acknowledge[d] rampant fraud, but blamed it on by then ex-MSH employee Daniel Dorce." (Id. ¶ 105.) And, the Complaint identifies by name thirty-nine employees of Defendants who allegedly participated in or were aware of the fraud. (Id. ¶ 75.)

Section 3729(a)(1)(B) – Fraudulent Records or Documents

Defendants contest the first two elements of Relators' Section 3729(a)(1)(B) claims, arguing that the creation of false or fraudulent records is not "supported by particularized details" and that Relators "fail to specify facts demonstrating scienter." (Defs.' Mem. at 18, 21.) Defendants also argue that Relators' "doctor swapping" allegations are not "material." (Id. at 8–9 ("These so-called 'doctor swapping' allegations fail for lack of materiality, because the FCA does not reach instances of regulatory noncompliance that are irrelevant to the government's disbursement decisions.") (internal citation and quotation marks omitted).) Defendants contend that in each incident identified by Relators, "the physician who performed the service was in fact authorized to bill Medicare." (Id. at 8–9.)

Relators counter that the Complaint provides sufficient particularity regarding fraud because it alleges "about two dozen illustrative examples of fraudulent billing." (Opp. at 2 (citing Compl. ¶¶ 81-88, 91, 95(a)-(i), 96 and 99).) Relators argue that these "allegations clearly show Defendants had both motive and opportunity to commit fraud, and they constitute strong circumstantial evidence of conscious misbehavior or recklessness--if not a specific intent to defraud." (Opp. at 17.) Relators also contend that "that putting the name of a doctor on a bill or medical record and submitting it to Medicare is material to [the Centers for Medicare and Medicaid Services'] reimbursement decisions." (Id. at 12.)

The Court finds that Defendants' arguments fail for substantially the same reasons discussed supra pp. 17–20. For example, each of the instances of "doctor swapping" sets forth required detail and each alleges the intentional and fraudulent alteration of an underlying medical treatment record.

(See, e.g., Compl. ¶ 81 ("[A] biller whited out Dr. Pawha's name, and by cutting and pasting, substituted Dr. Sacher's name on the narrative report").)

The Court also finds that scienter is shown by, among other things, Defendants' alleged alteration of medical treatment records which was, according to the Complaint, done at the direction of Dorce. (Id. ¶ 99 ("Dorce regularly instructed MSH Radiology Billing Department staff to 'cut and paste' the signature of nonparticipating physicians on reports with the signature of participating physicians, by literally cutting and pasting the participating physician's signature into the report, when insurance companies requested the report.").) See Novartis II, 2014 WL 2619014, at *5 ("The Relator supports these allegations by describing the defendants' intentional involvement with the [fraudulent billing] scheme . . . . The scienter allegations suffice.").

The Court also finds the "doctor swapping" allegations are material. "[T]he test for materiality is an objective one. . . . The fact-finder must determine only whether the proven falsehoods have a 'natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.'" U.S. ex rel. Feldman v. van Gorp, 697 F.3d 78, 95 (2d Cir. 2012) (quoting 31 U.S.C. § 3729(b)(4)). The Complaint alleges that the doctors who rendered the medical treatment in at least six of the "doctor-swapping" examples were not eligible to bill Medicare. (Compl. ¶¶ 81 ("[T]he claim was rejected on the ground that the physician was not certified/eligible to be paid for the service."); 87 ("Dr. Delman was eligible for payment by Medicare; Dr. Law was not."); 88 ("The report is signed by Dr. Mitty, who was not Medicare eligible, but Defendants submitted a bill that falsely states that services . . . were rendered by Dr. Wilck, who was eligible for payment by Medicare."); 95(a) ("[T]he claim was rejected on the ground that the provider was not certified"); 95(d) ("Dr. Khanna was not credentialed with Medicare."); 99 ("Dorce instructed Relator Ortiz, in sum and substance, to change the name of the physician who signed a report to

substitute Dr. Weintraub, a participating doctor, in place of Dr. Lookstein, who was a non-participating physician, in order to make the service billable.").) "Swapping" the name of an eligible doctor for an ineligible one would have a "natural tendency to influence, or be capable of influencing, the payment or receipt of money." Feldman, 697 F.3d at 95.

Section 3729(a)(1)(G) – Wrongful Retention

Defendants argue that Relators' wrongful retention allegations "are doubly deficient under Rule 9(b), not only because they are speculative and devoid of particularity—indeed, Relators do not describe even a single specific instance of alleged wrongful retention—but also because they are expressly based on 'information and belief.'" (Defs.' Mem. at 22.) Relators are "insiders with direct access to the Defendants' practices and the relevant billing records [and] FCA and NY FCA claims premised on 'mere information and belief' are foreclosed as a matter of law." (Id.) Relators counter that the Complaint "alleges that each Defendant is liable for violating the current and prior versions of the FCA and NYS FCA by . . . retaining funds received as a result of [fraudulent] acts" (Opp. at 1) and "describes events that triggered Defendants' notice of overpayments, e.g., ¶¶ 89–93" (Id. at 19) which were allegedly not refunded. Relators quote senior auditors telling Ortiz, "in substance, that Defendants could not make full refunds of overpayments to the government programs." (Id. at 19; see e.g., Compl. ¶ 104 ("Sackman expressly rejected Relator Ortiz' [sic] recommendation and said MSH would never inform Medicare, Medicaid, or any insurance company of the fraud, but rather would handle it internally.").) Relators also argue that "[o]nly Defendants have the internal investigation and accounting records that might show if full refunds have been paid [to Medicare or Medicaid] within the required 60 days [and] it is entirely appropriate for the [Complaint] to base its allegations [of wrongful retention] upon information and belief." (Opp. at 19–20.)

As noted supra p. 13, "to prove a claim under [(a)(1)(G)], a plaintiff must show: (1) proof that the defendant made a false record or statement (2) at a time that the defendant had a presently-existing obligation to the government—a duty to pay money or property." Novartis II, 2014 WL 2619014, at *10 (internal quotation marks omitted). This "standard expressly requires no proof of specific intent to defraud," Kane, 2015 WL 4619686, at *5, and a plaintiff "need not prove that the defendant submitted a false claim for repayment." Novartis II, 2014 WL 2619014, at *10 (citing Chesbrough, 655 F.3d at 473.)

The Court finds that Relators have met the requirements of pleading wrongful retention under § 3729(a)(1)(G) of the FCA. First, as noted supra pp. 16-19, the Complaint adequately alleges, with illustrative examples, that Defendants "made false records or statements" and submitted fraudulent bills to Medicare and Medicaid. (See also Compl. ¶¶ 61, 68, 75(d)(3), 77, 104 ("Relator Ortiz uncovered and reported to employees or representatives in the MSH Audit & Compliance Services Department that approximately 40% of the Medicare claims and 50% of the New York Medicaid claims records she had reviewed were fraudulent or improper"); ("At least as late as the end of 2010 or start of 2011 . . . Defendants routinely and knowingly submitted . . . claims [which] were fraudulent in that they were based on doctor swapping, upcoding, phantom billing, multiple billing and/or combined instances of fraud.").)

Second, the Complaint unequivocally establishes that, at the time of making false statements or records, Defendants had an "obligation to the government—a duty to pay money or property." Novartis II, 2014 WL 2619014, at *10. For example, Relators allege that "Defendants, through Audit & Compliance Services Department employees Frank Cino, Bruce Sackman, Darrick Fuller, Tracy Davis and Marie Diaz, conveyed to Relator Ortiz that they were aware the payments Defendants received as a result of the fraudulent practices alleged in this complaint were received

unlawfully and would have to be refunded to Medicare and Medicaid." (Compl. ¶ 120.) During this period, Defendants had a statutory duty to pay back overpayments from Medicare or Medicaid. 42 U.S.C.A. § 1320a-7k(d)(1)(A) (effective Mar. 23, 2010) (When a person "has received an overpayment, the person shall—(A) report and return the overpayment to the Secretary, the State . . . ."); see also Kane, 2015 WL 4619686, at *5 ("The ACA provides that any person who has received an overpayment from Medicare or Medicaid and knowingly fails to report and return it within sixty days after the date on which it was identified has violated the FCA.") Relators have adequately alleged that Defendants continued to receive overpayments until at least the end of 2010, had notice of those overpayments by September of 2010, and had a duty to return—but did not return—these overpayments under the PPACA. (See, e.g., Compl. ¶¶ 39, 58, 94.)

Defendants' argument that Relators' wrongful retention claims are premised on "mere information and belief [and] are foreclosed as a matter of law," (Defs.' Mem. at 22), is unpersuasive. Relators may rely "upon information and belief" for the purpose of pleading that Defendants did not refund the payments, as "[o]nly Defendants have the internal investigation and accounting records that might show if full refunds have been paid." (Opp. at 20; see also Wexner v. First Manhattan Co., 902 F.2d 169, 172 (2d Cir. 1990) ("Despite the generally rigid requirement that fraud be pleaded with particularity, allegations may be based on information and belief when facts are peculiarly within the opposing party's knowledge."); Lindner v. Int'l Bus. Machines Corp., No. 06 CV 4751 (RJS), 2008 WL 2461934, at *5 (S.D.N.Y. June 18, 2008) ("[W]here, as here, plaintiff alleges facts that are peculiarly within the opposing party's knowledge-namely, the statements allegedly made by defendants to third-parties in private conversations-plaintiff cannot be faulted, at this stage of the case, for asserting such facts on the basis of 'information and belief.'").

(4) Relators Adequately Plead Medicaid Fraud

Defendants argue that "Relators have 'failed to allege any specific claims relating to Medicaid,'" (Defs.' Mem. at 23 (quoting Mooney, 2013 WL 1346022, at *6)) and that the Medicaid counts in the Complaint should be dismissed "in their entirety." (Defs.' Mem. at 24); (Compl. ¶¶ 136–45.) Relators counter that they have alleged Medicaid fraud adequately. (Opp. at 21 ("[T]there are more than enough Medicaid allegations in the [Complaint] to satisfy the rule's particularity pleading requirement.").) Specifically, "Relators witnessed fraudulent Medicaid billing practices 'on a near-daily basis' while employed by Defendants" and they "frequently spoke to their supervisors about these Medicaid fraud practices, which included instances of: (a) 'doctor swapping'; (b) 'upcoding'; (c) 'phantom billing'; (d) multiple billing'; (e) 'combination misbilling'; and (f) 'wrongful retention.'" (Id. at 22–23.) The Complaint "alleges that Relator Ortiz participated in an internal audit of reimbursed Medicaid claims which revealed that approximately 50% of [claims] were either fraudulent or improper for the foregoing reasons." (Id. at 23.) And, "Defendants' internal auditors acknowledged to Relator Ortiz that the payments Defendants received as a result of the fraudulent practices she had witnessed and uncovered, as summarized in the [Complaint], had to be refunded to Medicaid." (Id.)

Relators also point out that the Complaint contains "specific examples of false or fraudulent Medicaid billing," and they cite to paragraphs: **86** ("Defendants double billed Medicare, and Medicare paid double, for the MRI of the cervical spine and for the MRI of the thoracic spine. In addition, Medicaid paid a portion of the charges for these tests."); **95(d)** ("[T]he report was signed by Dr. Khanna. Dr. Khanna was not credentialed with Medicare; and the invoice record for this service reflects that a claim was submitted identifying Dr. Yeh as the physician who performed the

service. Medicare and Medicaid paid a portion of this claim."); **96** ("On August 4, 2010, Dorce told Relator Ortiz, in sum and substance, to change the date of service on two claims to HealthFirst, a Medicaid HMO."); and **99** ("[W]ith respect to a claim for reimbursement to Fidelis, a Medicaid HMO, [Dorce] instructed Relator Ortiz, in sum and substance, to change the name of [physicians] in order to make the services billable" and "Dorce further instructed Relator Ortiz on or about August 10, 2010, in sum and substance, to change the name of the physician who signed a report to substitute Dr. Sacher, a participating doctor, in place of Dr. Chan, who was a non-participating physician."). (Opp. at 24.)

The Court finds that these examples of alleged Medicaid fraud are sufficient to survive Defendants' motion to dismiss. See Wells Fargo Bank, N.A., 972 F. Supp. at 617 ("[T]en . . . examples, drawn from throughout the time period the . . . scheme occurred, appear sufficient in all material respects, including general time frame, substantive content, and relation to the allegedly fraudulent scheme" (internal citation and quotation marks omitted)); see also Novartis VII, 2015 WL 109934, at *23–24 ("[T]he requirement that a plaintiff provide 'representative' sample claims does not mean that a plaintiff must provide sample claims from each program on behalf of which he has brought suit."); Harrison v. Westinghouse Savannah River Co., 176 F.3d 776, 784 (4th Cir. 1999) ("A court should hesitate to dismiss a complaint under Rule 9(b) if the court is satisfied (1) that the defendant has been made aware of the particular circumstances for which [it] will have to prepare a defense at trial, and (2) that plaintiff has substantial prediscovery evidence of those facts.").

(5) Relators Adequately Allege the Involvement of All Three Defendants

Defendants argue that Relators fail to distinguish among the three defendants—Mount Sinai Hospital, Mount Sinai School of Medicine, and Mount Sinai Radiology Associates—and "confuse

the roles allegedly played by each Defendant." (Defs.' Mem. at 20.) After arguing that Mount Sinai School of Medicine (not Mount Sinai Hospital) was the entity responsible for billing (and submitting requests for, and receiving, payment), Defendants propose that "if this case were to proceed—which it should not—[Mount Sinai School of Medicine] would be the only properly named defendant." (Defs.' Mem. at 21 n.34.) Relators counter that the Complaint "clearly outlines the Defendants' and their employees' respective roles," in the fraudulent billing schemes. (Opp. at 18 (citing Compl. ¶¶ 13–19, 70–74 and 75).)

The Court finds that the Complaint adequately alleges the involvement of all three Defendants. Relators offer "detailed allegations about the mechanics of the [fraudulent billing] schemes and the involvement of the [] Defendants." See Novartis II, 2014 WL 2619014, at *4. According to the Complaint, "[t]he healthcare services and related administrative activities underlying the false and fraudulent claims alleged in this complaint occurred at MSRA's offices" (Compl. ¶ 70); "the MSH Radiology Billing Department performed all billing functions, including billing Medicare and Medicaid for goods and services . . . for radiology services provided by the MSH Department of Radiology . . . and the MSRA" (Id. ¶ 17); and "MSSM was the entity in whose name the claims at issue were submitted to Medicare and Medicaid, and, presumably, was also the entity that received the corresponding reimbursement payments." (Id. ¶ 14).

"[B]ased on the common ownership, common management, and lack of meaningful separation . . . . the complaint sufficiently states a . . . claim against [Defendants]." U.S. ex rel. Mooney v. Americare, Inc., No. 06-CV-1806 FB VVP, 2013 WL 1346022, at *8 (E.D.N.Y. Apr. 3, 2013); see also Compl. ¶¶ 13-16 (alleging that "MSH and MSSM together are known as the Mount Sinai Medical Center . . . . [and] Defendant MSRA is a private practice group affiliated with MSH and MSSM.") Defendants may renew their argument to dismiss particular entities following the

completion of discovery and at the summary judgment stage if Relators are unable to adduce proof of a particular Defendant's involvement in an alleged fraudulent billing scheme. Id. at *8 n.9.

IV. Conclusion & Order

For the reasons stated herein, Defendant's motion to dismiss [#30] is denied. The parties are directed to appear on November 17, 2015 at 9:00 a.m. for a settlement/scheduling conference and to engage in good-faith settlement discussions prior to the conference.

Dated: New York, New York
November 9, 2015

RMB

RICHARD M. BERMAN, U.S.D.J.