15-3930-cv

In The
United States Court of Appeals
For the Second Circuit

Paul Fabula, ex rel. USA, bringing this action on behalf of himself and the United States of America

Plaintiff-Appellant

Ronald I. Chorches, Trustee for the Bankruptcy Estate,

Plaintiff-Appellant

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On Appeal from the United States District Court
for the District of Connecticut
(Hon. Michael P. Shea)

JOINT APPENDIX
VOLUME II OF II
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United States of America,

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v.

American Medical Response, Inc.

Defendant-Appellee.

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JOINT APPENDIX

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UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

UNITED STATES ex rel. RONALD I. CHORCHES Bankruptcy Trustee, Bringing this action on behalf of THE UNITED STATES OF AMERICA, the ESTATE OF PAUL FABULA, and PAUL FABULA, Individually Plaintiff-Relator, v. AMERICAN MEDICAL RESPONSE, INC., Defendant.	Civil Action No. 3:12-CV-921 MPS May 11, 2015

DEFENDANT'S MOTION TO DISMISS THIRD AMENDED COMPLAINT

Relator's[1] Third Amended Complaint ("TAC") still suffers from the same substantive defects as did the Second Amended Complaint ("SAC"): an abundance of conclusory allegations and a fatal lack of specific, material detail about specific false claims to justify a finding of fraud. Most glaringly, the TAC still does not identify a single false claim that AMR, in fact, submitted to the government for payment, which alone is fatal to the TAC. Moreover, the TAC still fails to set out the necessary specific details about the yarns Relator includes, including who at AMR

[1] "Relator" as used herein refers to Ronald Chorches (also occasionally, the "Trustee"), who was recently substituted as Relator based on the Court's ruling that original relator Paul Fabula's ("Fabula") lacked standing due to his failure to disclose these claims as an asset in his previously dismissed, now reopened, bankruptcy action.

allegedly filled-out false Patient Care Reports ("PCRs"), regarding what patients, when such PCRs were completed, and their content, let alone why their content was false.

Thus, as with the SAC, the TAC is subject to dismissal pursuant to Federal Rules of Civil Procedure 12(b)(6) and 9(b) and Defendant American Medical Response, Inc. ("AMR") accordingly adopts its previously filed Motion to Dismiss (Dkt. 40) and Memorandum ("Mem." Dkt. 40) and Reply (Dkt. 59) in support of the previous Motion, as supplemented with the accompanying memorandum of law.

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CERTIFICATE OF SERVICE

I hereby certify that, on May 11, 2015, a copy of the foregoing paper was filed electronically and served by mail on anyone unable to accept electronic filing. Notice of this filing will be served by e-mail to all parties by operation of the court's electronic filing system or by mail to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing.

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UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

UNITED STATES ex rel. RONALD I. CHORCHES Bankruptcy Trustee, Bringing this action on behalf of THE UNITED STATES OF AMERICA, the ESTATE OF PAUL FABULA, and PAUL FABULA, Individually Plaintiff-Relator, v. AMERICAN MEDICAL RESPONSE, INC., Defendant.	Civil Action No. 3:12-CV-921 MPS May 11, 2015

MEMORANDUM IN SUPPORT OF DEFENDANT'S MOTION TO DISMISS THE THIRD AMENDED COMPLAINT

Relator's Third Amended Complaint ("TAC") still suffers from the same substantive defects as did the Second Amended Complaint ("SAC"): an abundance of conclusory allegations and a fatal lack of specific, material detail about specific false claims actually submitted to the government, and the who, what, and where of the alleged frauds. Thus, as with the SAC, the TAC is subject to dismissal pursuant to Federal Rules of Civil Procedure 12(b)(6) and 9(b).[1] Despite having now had four opportunities to adequately plead his claims and the benefit of a detailed opinion from the Court, this fourth attempt still fails, leading to the inescapable

[1] "Relator" as used herein refers to Ronald Chorches (also occasionally, the "Trustee"), who was recently substituted as Relator based on the Court's ruling that original relator Paul Fabula's ("Fabula") lacked standing due to his failure to disclose these claims as an asset in his previously dismissed, now reopened, bankruptcy action.

ORAL ARGUMENT REQUESTED

conclusion that Relator simply does not have a cause of action to allege. The TAC fails for the same reasons identified by Defendant American Medical Response, Inc. ("AMR") in its previously filed Motion to Dismiss. As such, AMR renews and supplements its prior Motion to Dismiss the Second Amended Complaint (Dkt. 40) and incorporates by reference the Memorandum ("Mem." Dkt. 40) and Reply (Dkt. 59) in support of the previous Motion.[2] Having swung and missed for a fourth time, Relator's claims should be dismissed with prejudice (and without prejudice to the United States).

Although the TAC provides more details such as the names of Fabula's co-workers – information that could have been alleged previously, had it been relevant – the TAC persists in impermissibly pleading based on generalities, conclusions, and characterizations rather than specific facts as required by Fed. R. Civ. P. 9(b). Most glaringly, the TAC still does not identify a single false claim that AMR, in fact, submitted to the government for payment; this failure is fatal to the TAC. Relator's speculative allegations of submission "on information and belief" do not rescue the claims. *See* Point I, *infra*. Moreover, the TAC still fails to set out the necessary specific details about the yarns Relator includes, including who at AMR allegedly filled-out false Patient Care Reports ("PCRs"), regarding what patients, when such PCRs were completed, and their content, let alone why their content was false. Merely scattering one or two details in the TAC for a couple of PCRs does not satisfy Rule 9(b). *See* Point II.A., *infra*.

Notably, the TAC abandons the Second Amended Complaint's "nationwide" claims theory, instead limiting the scope of the action to Connecticut only. The TAC also does not

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[2] To avoid additional voluminous submission to this Court, AMR attempts not to repeat arguments, citations to authority, and facts set forth in its prior Memorandum, and requests that this Court consider both this submission and the citations to the prior Memorandum and Reply in determining whether the TAC should be dismissed.

renew Fabula's separate retaliation claim, thereby abandoning that claim as well. *See* Points II.B. and C, *infra*.[3] At its root, however, the TAC continues to suggest that AMR's efforts to improve documentation (and therefore maximize revenue legitimately) violate the False Claims Act ("FCA"), 31 U.S.C. § 3729, *et seq.*; as discussed herein and in AMR's prior submissions, those efforts are not a violation. In short, Relator's allegations continue to shrink and should be finally and fully dismissed.

I. THE THIRD AMENDED COMPLAINT STILL FAILS TO IDENTIFY OR PLEAD ANY DETAILS REGARDING A SINGLE FALSE CLAIM SUBMITTED AS REQUIRED BY RULE 9(b).

A. Relator Fails To Plead Specific Details of Claims Actually Submitted.

The sole count of the TAC, like Count I of the SAC, purports to assert claims under Sections 3729(a)(1)(A) and (a)(1)(B) of the FCA. TAC at p. 36. An essential element under either of these sections is the actual submission to the government of an actual false claim. *See U.S. ex rel. Kester v. Novartis Pharmaceuticals Corp.*, No. 11 Civ. 8196 (CM), 2014 U.S. Dist. LEXIS 81180, at *16-17 (S.D.N.Y. June 10, 2014); *U.S. ex rel. Aflatooni v. Kitsap Physician Servs.*, 314 F.3d 995, 997 (9th Cir. 2002) ("It seems a fairly obvious notion that a False Claims Act suit…requires a false claim…This flaw is fatal to a *qui tam* action under the False Claims Act."); *see also* Mem. at 11-12, 19-22. An actual false claim is the *sine qua non* of an FCA violation. *U.S. ex rel. Clausen v. Lab. Corp. of Am., Inc.*, 290 F.3d 1301, 1311 (11th Cir. 2002); *U.S. ex rel. Polansky v. Pfizer, Inc.*, No 04-cv-0704 (ERK), 2009 U.S. Dist. LEXIS 43438, at *13 (E.D.N.Y. May 22, 2009) (citing *Clausen*). Accordingly, the vast majority of district court

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[3] Tellingly, the TAC simply omits all prior allegations regarding Fabula's prior service as a medic and how he allegedly began to suspect impropriety at AMR well in advance of his bankruptcy filing. *See* SAC (Dkt. 39) ¶¶ 8, 82-86, 129; Mem. 23-24; Reply 12-13. These were the cornerstones of Fabula's "nationwide" allegations; he apparently realized in his TAC that they also established he had knowledge of his allegations against AMR well before he filed for bankruptcy. *See* Point II.B., *infra*.

authority within the Second Circuit, including these three cases from 2014, have required a relator to identify and allege the details of *specific false claims* to satisfy Rule 9(b). *See Kester*, 2014 U.S. Dist. LEXIS 81180, at *19; *U.S. ex rel. Corp. Compliance Assocs. v. N.Y. Society for the Relief of the Ruptured and Crippled,* No. 07 Civ. 292 (PKC), 2014 U.S. Dist. LEXIS 109786, at *4 (S.D.N.Y. Aug. 7, 2014); *U.S. ex rel. Joseph v. The Brattleboro Retreat*, No. 2:13-cv-55, 2014 U.S. Dist. LEXIS 110154, at *28 (D. Vt. Aug. 10, 2014); *see also* Mem. at 13-14, 18-22.[4]

The TAC still does not identify a single false claim actually submitted to the government. Instead, Relator uses specific language to avoid alleging the submission of a false claim; for example, in paragraph 12, he alleges that some of the runs that Fabula performed were "reimbursable" (not "reimbursed") by Medicare. Relator has not, because pursuant to Rule 11 he cannot, plead that any of Fabula's transports were, in fact, reimbursed by Medicare or submitted to Medicare for reimbursement. This is the crucial difference. Thus, for the same reasons set out in AMR's prior Memorandum, the TAC should be dismissed. *See* Mem. at 13-14, 18-22. To state a viable claim a relator must plead specific details of false claims actually submitted to the government by "(1) identifying which of the claims that the defendant submitted were 'false,' and (2) providing a factual basis (as opposed to mere speculation) to support the plaintiff's assertion that claims were actually submitted to a government program." *Kester*, 2014 U.S. Dist. LEXIS 81180, at *18.

Here, Relator has still not done either, instead continuing to plead generically (now "on information and belief") that false claims were submitted. TAC ¶¶ 19, 105, 108. This "information and belief pleading" is based entirely on his allegation that AMR bills Medicare for

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[4] The *Corp. Compliance Assocs.* and *Joseph* cases were both decided after briefing was completed on the prior Motion to Dismiss, and therefore present further recent authority from district courts within the Second Circuit supporting dismissal of the TAC.

some patients, rather than any specific knowledge as to whether AMR ever submitted a bill for *these* patients, whether it submitted a bill for any patients it was not entitled to bill for, or whether it submitted a bill for any *particular* patients.

In fact, rather than alleging new details regarding actual false claims or billing at AMR, in the TAC Fabula admits he has no knowledge whatsoever about AMR's billing processes because he was "not involved in billing Medicare or Medicaid for…ambulance runs," and, in fact, had never even entered the building where the billing was done. TAC ¶ 115. Relator therefore does not know – and cannot allege – whether AMR in fact filed claims for even the limited number of patients for whom he presents any allegations whatsoever. *See* First Amended Complaint ¶ 33 (Dkt. 10) (Relator alleges he "did not participate in, nor was he exposed to, the submission of bills to the Government or the private carriers administering Medicaid."); *see also, e.g., U.S. ex rel. Gravett v. The Methodist Med. Ctr. of Ill.*, No. 12-1008, 2015 U.S. Dist. LEXIS 26083, at * 15 (C.D. Ill. Mar. 4, 2015) (dismissing on Rule 9(b) grounds where, although relator identified 16 patients whose charts were allegedly upcoded, he "fail[ed] to provide specific information of at least a single false claim that was actually submitted for payment.").

The TAC still amounts to no more than inadequate allegations that claims "must have been submitted, were likely to be submitted, or should have been submitted," *Clausen,* 290 F.3d at 1311, which does not satisfy Rule 9(b). *Id.*; *see also* Mem. at 20-21; *Kester*, 2014 U.S. Dist. LEXIS 81180, at *24. To allow Relator a ticket to discovery based on such conclusory and speculative allegations is not in accord with the purposes of Rule 9(b) and should not be allowed. *See Clausen*, 290 F.3d at 1312 n.21 ("We cannot make assumptions about a False Claims Act defendant's submission of actual claims to the Government without stripping all meaning from Rule 9(b)'s requirement of specificity or ignoring that the 'true essence of fraud' of a False

Claims Act action involves an actual claim for payment and not just a preparatory scheme."); *see also Corp. Compliance Assocs.*, 2014 U.S. Dist. LEXIS 109786, at *38 (quoting *Clausen*); Reply at 5-7.

B. The Court Should Not Permit Relator To Invoke a Relaxed Pleading Standard.

Acknowledging his pleading deficiencies, Relator attempts – as in the Opposition to AMR's prior Motion to Dismiss – to justify his lack of compliance with Rule 9(b) by alleging that the billing information is exclusively "within the possession, custody, or control of AMR" and not accessible to Fabula. TAC ¶¶ 110, 115. Relator does not, however, allege enough to trigger such a relaxed Rule 9(b) standard. Reply at 9-12; *see also Corp. Compliance Assocs.*, 2014 U.S. Dist. LEXIS 109786, at *50 (refusing to allow relator to avoid 9(b) by asserting lack of access to information); *Mooney v. Americare, Inc.*, No. 06-CV-1806, 2013 U.S. Dist. LEXIS 48398, at *9-10 (E.D.N.Y. Apr. 3, 2013) (under a relaxed Rule 9(b) standard, a complaint "must still adduce specific facts supporting a strong inference of fraud."); *U.S. ex rel. Klein v. Empire Educ. Corp.*, 959 F. Supp. 2d 248, 257 (N.D.N.Y. Aug. 13, 2013) (dismissing on 9(b) grounds; even under a relaxed pleading standard, a "claim must still allege a factual nexus between the improper conduct and the resulting submission of a false claim to the government.") (citations omitted).

Relator is not entitled to a relaxed pleading standard even assuming, *arguendo*, that he did not have access to AMR's billing department. Where a relator fails to plead details regarding any false claims submitted, "[i]t is not a satisfactory answer that [relator] lacks the information to address" that issue. *Corp. Compliance Assocs.*, 2014 U.S. Dist. LEXIS 109786, at *50. The FCA is simply not intended as a catch-all fraud statute and a relator must possess specific proof

that a defendant submitted fraudulent claims for payment in order to proceed. *See* Point I.A., *supra* (citing cases dismissing claims for failure to allege claims submission); Reply at 9-10.

Further, even were the relaxed pleading to be applied (it should not be) Relator does not satisfy such a standard. *See* Reply at 10-12. Relator cannot simply state that he does not have access to pertinent documents and then use "information and belief" as a repeated mantra to avoid supplying any details at all establishing that claims were actually submitted. "Relaxation does not mean that a plaintiff can plead offering no detail at all." *Kester,* 2014 U.S. Dist. LEXIS 81180, at *19. Even under a relaxed pleading standard, a relator must plead, with particularity, "*specific facts* supporting a strong inference" that a false claim was actually submitted to the government. *Johnson v. The Univ. of Rochester Med. Ctr.*, 686 F. Supp. 2d 259, 267 (W.D.N.Y. 2010) (emphasis added). It is impermissible to base claims of fraud on "speculation and conclusory allegations." *Mooney,* 2013 U.S. Dist. LEXIS 48398, at *10 (quoting reference omitted). Here, Relator's allegations are still wholly conclusory. Relator does not provide any claim numbers, does not provide the dates that any improper bills were supposedly submitted, nor the claim amounts or reimbursement amounts – even on information and belief. This too does not satisfy Rule 9(b). *U.S. ex rel. Smith v. Yale Univ.*, 415 F. Supp. 2d 58, 86-87 (D. Conn. 2006) (finding relator did not satisfy Rule 9(b) where relator did not identify the amount of any charges, the dates of the false claims, any bills submitted or any payments received).

Johnson is instructive. There the relators (a doctor named Johnson and an R.N. named Schmidt) alleged that medical facilities billed Medicare for anesthesia procedures that required a supervising physician be present when one was not. 686 F. Supp. 2d at 263. As in this case, Schmidt alleged that she was told that if she did not indicate certain items on paperwork the defendant "[would not] be able to bill for the case." *Id.* at 265. In their complaints, Schmidt and

Johnson described the practices they alleged to be fraudulent, including specific types of procedures that were allegedly unsupervised. With regard to the claims submission, however, they did not identify any instances of billing to Medicare or Medicaid, instead generically alleging that the medical center engaged in a fraudulent scheme to improperly bill and obtain payments from Medicare and Medicaid. *Id.* at 265, 268. The court dismissed the amended complaint, holding that such generic allegations did not satisfy even a relaxed 9(b) standard. *Id.* at 268.

Similarly here, Relator alleges that Fabula was told that Medicare could not be billed for PCRs as written, but fails to connect this generic allegation to any specific claims submitted by AMR for payment. In fact, Relator largely fails to even allege that patients were Medicare or Medicaid recipients at all; as a result he has not even plausibly alleged that a false claim was or could have been submitted to the United States for that patient. *See id.* at 266 (Rule 9(b) not satisfied where relator "d[id] not even allege that any of the falsified records related to Medicaid or Medicare patients" and therefore "merely *speculate[d]* that a claim might exist) (emphasis in original); *Gravett*, 2015 U.S. Dist. LEXIS 26083, at *15 (Rule 9(b) was not satisfied where relator did not identify any bills submitted to Medicare or Medicaid and did not allege any facts to "exclude the possibility that Defendants billed private payors or insurance companies" for the patients referenced in the Complaint). Relator's scant references to Medicare do not clear the bar, as he still does nothing more than attempt to allege a fraudulent scheme and then assert that "false claims must have been submitted."[5] *Johnson,* 686 F. Supp. 2d at 266. This does not satisfy even a relaxed Rule 9(b) standard. *Id.*

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[5] As discussed below, even were Relator's vague and conclusory claims allegations enough to satisfy a relaxed 9(b) standard, the TAC should still be dismissed because Relator also still fails to allege the details of a fraudulent scheme with particularity and Relator cannot utilize a relaxed pleading standard

After four attempts, Relator still does not plead the submission to the government of any identifiable false claims with the specificity required by Rule 9(b). The TAC should be dismissed with prejudice.

II. THE FEW DETAILS ADDED IN THE THIRD AMENDED COMPLAINT STILL FAIL TO ADEQUATELY PLEAD AN ALLEGED FRAUDULENT SCHEME.

In addition to failing to plead actual submission to the government of false claims (Point I, above), the TAC also still fails to allege any fraudulent scheme or improper practices at AMR with the specificity required by Rule 9(b), and should be dismissed on this separate and ground as well.

A. The Third Amended Complaint Still Does Not Plead the Who, What, Where, and When of Any Alleged Fraudulent Scheme or Improper Behavior.

In addition to the requirement to specifically plead actual submission of a claim, in order to satisfy Rule 9(b) a relator must also plead the particulars of both an underlying fraudulent scheme *and* the false claims actually submitted with particularity. *See* Mem. at 12-14, 19-20; *see also Corp. Compliance Assocs.*, 2014 U.S. Dist. LEXIS 109786, at *35. While Relator sprinkles in an additional alleged detail here and there, the TAC still fails to cure the pleading defects in the SAC and still falls far short of pleading with the specificity required by Rule 9(b). *See* Mem. 14-18. And there is no relaxed pleading standard for pleading a fraudulent scheme. *See supra*, n. 5.

Rule 9(b) requires that a relator must identify the "who, what, where, and when" of the alleged fraud. *Chen v. EMSL Analytical, Inc.*, No. 10 Civ. 7504 (RA), 2013 U.S. Dist. LEXIS 117030, at * 46 (S.D.N.Y. Aug. 16, 2013); *see also* Mem. at 12-13. There is not a single

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for those allegations. *See, e.g., Klein*, 959 F. Supp. 2d at 257 (indicating that, even where Rule 9(b) is relaxed as to the submission of claims, a relator must "still…plead the fraudulent scheme in detail."); *see* Point II.A., *infra*.

instance in the TAC, however, where Relator specifically alleges the patient, ambulance personnel, date, location, and content of the PCR that was allegedly false for a particular run. Unable to do so, Relator instead alleges isolated details for a few *different* runs. This does not satisfy Rule 9(b). Relator must allege the who, what, where, when, and how of an instance of fraud, not the who of one PCR, the where of another, and the date for a third. *See, e.g., U.S. ex rel. Grenadyor v. Ukrainian Vill. Pharm., Inc.*, No. 09 C 7891, 2013 U.S. Dist. LEXIS 138232, at *15 (N.D. Ill. Sept. 26, 2013) (dismissing Third Amended Complaint with prejudice because "pleading fraud with particularity requires providing at least one specific instance of wrongdoing that satisfied the who, what, where, when and how requirements of Rule 9(b).")

The closest the TAC gets to pleading with specificity are the allegations regarding a PCR from December 2011 that Fabula refused to complete and based on which he alleges he was terminated. TAC ¶¶ 71-76. Relator identifies the patient by name and address (yet another inexplicable violation of HIPAA, despite this violation having been identified in prior briefing), the date of the PCR, and the hospital the patient was transported to. *Id.* ¶ 71.[6] Relator then provides the revised narrative he was being asked to include. *Id.* ¶ 72. Even here, however, Relator does not indicate what about the narrative was false. By Relator's own admission, the narrative: "bed confined with severe contraction in the hands" satisfies Medicare's medical necessity requirement, and Relator does not dispute that the patient actually had this condition or multiple sclerosis (the underlying diagnosis). *Id.* ¶ 72-73. Instead he simply alleges that these

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[6] Relator's improper disclosure of Protected Health Information is both a violation of HIPAA and inconsistent with the Court's Electronic Filing Policies and Procedures, at III.C. ("Privacy"), U.S. Dist. Ct., D. Conn. (rev. October 10, 2013), available at http://ctd.uscourts.gov/sites/default/files/forms/PPADMIN-ORDER%20rev%2010.10.13.pdf ("litigants should not include sensitive information in any document filed with the Court unless such inclusion is necessary and relevant to the case"; "counsel is encouraged to exercise caution when filing documents that contain" personal identifying information.). *See also* 42 U.S.C. § 1320d-6.

"were not [his] words," *id.* ¶ 74, but that does not make the PCR false.[7] The only thing Fabula claims was "false" on the PCR he was being asked to revise was the time between when he arrived on scene (which he does not dispute) and the time he was at the patient's side (which he alleges would have been a few minutes later). *Id.* ¶¶ 75-76. But he does not allege that this impacted reimbursement in any way, could have been material to Medicare's billing decisions, or that he tried to fill the PCR out with the "correct" time but was told he could not. The fact that Relator does not allege falsity with regard to his centerpiece example despite the fact that he knows he is fighting for the survival of this litigation speaks volumes.

Moreover, this PCR cannot form the basis for a cause of action under the FCA because Relator admits that he never completed it. *Id.* ¶¶ 79-80. In fact, the TAC specifically alleges that because Fabula refused to fill out the PCR, AMR could not bill for this run and submit a claim to Medicare. TAC ¶ 83. By definition then, this PCR never served as the basis for a claim for payment and cannot constitute a false claim. 31 U.S.C. § 3729(b)(2)(A).[8]

The TAC identifies two other patients by name, but these allegations fare no better.[9] As alleged, the first patient was frequently transported to the hospital for his insulin, and Relator

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[7] A number of the allegations in the TAC are to a similar effect. *See* TAC, ¶¶ 44, 52, 90, 94-95, 103-104. But again – notwithstanding the apparent chagrin of Fabula and others in the "garage" – AMR did not violate the FCA by requiring its employees to document runs in a manner that will make them more likely to qualify for reimbursement. *U.S. ex rel. Colucci v. Beth Israel Med. Ctr.*, 785 F. Supp. 2d 303, 315 (S.D.N.Y. 2011) (finding that there was no falsity where relator "alleged nothing more than that [defendant] took steps to maximize its Medicare reimbursements").

[8] This demonstrates exactly why, as discussed in Point I above, relators are required to plead the actual submission of false claims with specificity. *See, e.g., Polansky,* 2009 U.S. Dist. LEXIS 43438 (The FCA "attaches liability, not to the underlying fraudulent activity…but to the 'claim for payment.'") (quoting reference omitted).

[9] These two patients were identified in the SAC as well. Curiously, in the face of a 9(b) challenge, in the TAC Relator *omits* details from those prior allegations regarding one of those patients. Thus, the allegations relating to these patients still suffer from the same defects, and more. *See* Mem. at 15 n.16.

alleges that Fabula was told to write on the PCR that the patient had difficulty remaining in an upright position. TAC ¶ 108. However, the TAC does not allege that this patient did not, in fact, have difficulty remaining upright or otherwise did not need an ambulance. Given the allegation of the patient's extreme obesity, *id*, the patient likely may well have had difficulty remaining upright. For the second patient, the TAC does not specify what was written on the PCR, much less why that was false, or even allege that any bills were submitted to Medicare for this patient. TAC ¶ 109.

Other "details" added to the TAC similarly fail to satisfy Rule 9(b)'s specificity requirements. The instances described in the TAC fail to identify one or more of what patients were allegedly improperly billed for, when the runs or any billing occurred, where the patients were transported to or from, what was written on the PCRs, and why what was written was false.[10] For example, Fabula alleges that he was required to rewrite two PCRs for "fall risks" that he "didn't agree with." TAC ¶ 44. He does not identify who those patients were, when this occurred, who the other ambulance personnel involved were, or where the patient was transported to or from. Moreover, his allegation that he "didn't agree with" the edit, TAC ¶ 44, does not mean any information in the revised PCR was false, just that Fabula thought it was fine

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[10] Similarly, the TAC references two unidentified patients transported on December 14, 2011 by Fabula and Amy Baitch. TAC ¶¶ 97-98. The TAC conclusorily alleges that these patients had "no reason to travel by ambulance," but does not identify those patients by initials, say what their conditions were, or indicate what was recorded in the PCR, much less anything false recorded in the PCR. *Id.* The TAC also references a named patient transferred with EMT Douglass Gladstone and conclusorily alleges the patient "had no medical reason to be sent to the hospital, he simply wanted to go there." TAC ¶ 100. However, the TAC does not allege that the patient could have been transported by a means other than an ambulance, does not identify the date of the run, and does not state what was recorded in the PCR at all, much less anything false. None of these allegations satisfy Rule 9(b).

as written.[11] *See* n. 7, *supra*. Because the TAC does not allege what Fabula disagreed with (or identify what PCR Fabula is referencing), it is impossible for AMR to defend these allegations other than to simply say it did not do anything wrong. This is precisely what Rule 9(b) seeks to prevent. *See U.S. ex rel. Williams v. Martin-Baker Aircraft Co.*, 389 F.3d 1251, 1259 (D.C. Cir. 2004) (to satisfy Rule 9(b) a relator must plead enough detail that a defendant can "defend against the charge and not just deny that they have done anything wrong.").[12]

Relator alleges that ambulance personnel would write previous surgeries on PCRs. *See, e.g.*, TAC ¶¶ 96, 102, 105. Relator does not allege that those past surgeries did not also lead to present conditions or residual effects (even if not the reason for the current hospital visit) that necessitated ambulance transport. For instance, the TAC alleges that Fabula was asked to transfer a patient from New Haven to Guilford and to indicate that the patient was unable to sit at a 90 degree angle due to a hip fracture. TAC ¶ 96. Relator alleges that the hip fracture was five years earlier and "the patient had already fully recovered"; however, he does not allege that the hip fracture did not have residual effects which prevented the patient from sitting at a 90 degree angle. *Id.* He also does not identify the specific patient, his partner on that run, or what he

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[11] The TAC's anecdotes of types of patients (e.g. needing assistance, hip replacements, dementia, unsteady gait or poor balance, fall risks, and unable to regulate their own oxygen) do not satisfy Rule 9(b) for the same reasons previously articulated. Mem. at 18 n. 19. Relator's sole "example" of a dementia patient similarly fails to state a claim. Fabula does not provide the patient's name, or the date or location of service. He alleges that when picking up the patient he asked a hospital liaison why ambulance transport was necessary. The liaison allegedly said that the patient had cancer and also wrote down dementia. TAC ¶¶ 84-85. When Fabula indicated that Medicare does not cover dementia transfers unless the patient is violent, the liaison reviewed the patient's medical record, saw a history of violence, and so indicated on the form. *Id.* at 85. More importantly, Relator does not dispute that the patient had dementia, and in fact alleges the patient *had* a history of violence. TAC ¶ 85. Relator accurately alleges that "[f]or patients with dementia who had a medical history of 'violence' the transport was reimbursable by Medicare." TAC ¶ 39. There is thus nothing false about this PCR.

[12] Relator again insists that AMR can determine what PCRs are at issue by looking at PCRs with amendments. AMR cannot do so because PCRs are amended for various legitimate reasons, including missing, incomplete, or incorrect information. *See* Mem. at 16-17; Reply at 6.

actually wrote on the PCR. For other patients with past surgeries, the TAC simply conclusorily alleges that the patients "did not actually require an ambulance" without any specificity regarding the patients' present conditions. TAC ¶ 102. Relator paints with a broad-brush, apparently hoping that the Court will not require him to fill in the details. This does not satisfy Rule 9(b), especially not where Relator has been given multiple chances including the most recent one where he had the benefit of the Court's opinion.

Relator also trots out new wholly permissible procedures that he attempts to spin as fraudulent. Relator alleges that, on October 17, 2011 Fabula picked up a patient, whom he concedes needed an ambulance to travel, and began taking that patient to the hospital, but, on the way the transport was cancelled because the patient's appointment was actually the next day. TAC ¶ 101. Fabula alleges that he nonetheless completed a PCR and, without alleging what was included in the PCR or even that the run was billed for, asks this court to infer wrongful conduct.[13] Rule 9(b) prohibits this type of inference. This allegation amounts to nothing more than an allegation that Fabula filled out paperwork to (correctly) indicate whom he transported by ambulance on a given day. This is not fraud.

As in the prior iterations, Relator persists in his baseless pursuit of a lawsuit that essentially alleges that AMR should be penalized for seeking to maximize the reimbursements it received from Medicare and Medicaid for ambulance transports; however, as AMR articulated in its prior Motion, this is not fraud. Mem. at 14; *U.S. ex rel. Williams v. Renal Care Grp., Inc.*, 696 F.3d 518, 528 (6th Cir. 2012) ("Why a business ought to be punished solely for seeking to

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[13] Once again Relator conflates completing a PCR with billing the government for a run. The two are not synonymous; just because a PCR was completed does not mean a run was submitted to the government for reimbursement. It could be billed to insurance or not billed at all. Neither would constitute a false claim pursuant to 31 U.S.C. § 3729.

maximize profits escapes us."). Relator likewise continues to allege entirely innocuous statements by AMR personnel (including in the context of mandatory training sessions meant to increase compliance) such as the need for documentation to be "better" or "clearer" and "meet company standards" are improper. TAC ¶¶ 52-53, 128, 134. Such statements are not indicative of fraud, and Relator cannot satisfy Rule 9(b) by resorting to what he "understood" these statements to mean, rather than what they actually were. Mem. at 17-18, n.18 (reviewing each alleged comment in the SAC and demonstrating how they are consistent with proper practice). Nor does such pleading get over the bar of Rule 12(b)(6). *See Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555 (2007) (allegations must be "more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do. Factual allegations must be enough to raise a right to relief above the speculative level."); *Id.* at 557 (describing conduct that is merely "consistent with" liability or fraud is not sufficient to avoid dismissal); *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (To survive a motion to dismiss, complaint must contain "factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged."); *Corp. Compliance Assocs.*, 2014 U.S. Dist. LEXIS 109786, at *51-52 ("conduct 'consistent with' liability fail[s] to satisfy both Rule 9(b) and *Twombly's* instruction that a plausible complaint must 'nudge[] [plaintiffs'] claims across the line from conceivable to plausible . . . .'") (quoting *Twombly*, 550 U.S. at 570).[14]

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[14] In addition to Relator's "core" allegations regarding medical necessity and PCRs, the TAC once again makes cursory allegations regarding physician certification statements, paramedic assessments, and indications that patients were bed confined. TAC ¶¶ 54, 141-148. The TAC does not add anything new to these allegations and they still fail to plead the essential elements of a cause of action under the FCA at all, much less with the specificity required by Rule 9(b) for the reasons previously briefed. Mem. at 25-30. In addition, despite a number of apparently random allegations, the TAC affirmatively abandons any claim based on AMR's alleged violation of the Corporate Integrity Agreement. TAC ¶ 123. Moreover, the TAC does not appear to state a separate claim based on false certification. While Count I mentions false certification, TAC ¶ 174, this appears to be just another way of restating the core medical necessity

B. Relator's "Nationwide" Allegations Are Abandoned in the Third Amended Complaint.

The TAC significantly narrows the scope of this FCA cause of action as compared to prior iterations by limiting its allegations (and the recovery sought) to AMR's conduct in Connecticut. TAC ¶¶ 37 ("This entire process took place at AMR's New Haven office"); 113 ("He witnessed this scheme…in the New Haven branch,…at AMR's branches serving Fairfield County, Greater Hartford/Northeast Connecticut, and Waterbury/Farmington Valley."); p. 24 (indicating in a heading that the TAC is describing "scope of the damages claimed in New Haven, Waterbury, Hartford, and Bridgeport"); *compare* SAC ¶¶ 81-86, 91-92, 137 (Relator's attempt to allege a "nationwide" cause of action against AMR). Because the TAC alleges that the conduct at issue occurred "in Connecticut," and does not attempt to extrapolate that to AMR nationally, the "nationwide" claims are no longer at issue. *See, e.g.,* TAC ¶ 165.

C. Fabula Does Not Attempt to Resuscitate, and Therefore Abandons, His Retaliation Claim.

In its March 4, 2015 Order, the Court dismissed Fabula's FCA retaliation claim with prejudice. Memorandum and Order at 19 ("Order"), Dkt. 67. Although in its subsequent April 3, 2015 order the Court gave Relator and Fabula the opportunity to file a third amended complaint as to both counts of the SAC, Dkt. 75, the TAC contains only a single count alleging substantive FCA violations. TAC at First Count, p. 36. Fabula has therefore abandoned any retaliation claim.

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claims. To the extent Relator is attempting to assert a separate claim for false certification, that claim fails to satisfy Rule 9(b) because the TAC does not identify any specific false certifications submitted to Medicare or Medicaid. Mem. at 22.

CONCLUSION

For the foregoing reasons and those set forth in AMR's Memorandum and Reply in support of its Motion to Dismiss the Second Amended Complaint (Dkt. 40, 59), AMR respectfully requests that this Court grant its Motion to Dismiss and Dismiss Relator's claims in their entirety with prejudice.

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CERTIFICATE OF SERVICE

I hereby certify that, on May 11, 2015, a copy of the foregoing paper was filed electronically and served by mail on anyone unable to accept electronic filing. Notice of this filing will be served by e-mail to all parties by operation of the court's electronic filing system or by mail to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing.

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UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

UNITED STATES ex rel. RONALD I. CHORCHES, Bankruptcy Trustee, Bring this action on behalf of the UNITED STATES OF AMERICA, the ESTATE OF PAUL FABULA, and PAUL FABULA, Individually, Plaintiff-Relator, v. AMERICAN MEDICAL RESPONSE, INC., Defendant.	C.A. No. 3:12-CV-921 MPS

PLAINTIFF-RELATOR'S OPPOSITION TO DEFENDANT'S MOTION TO DISMISS THE THIRD AMENDED COMPLAINT

Defendant, American Medical Response, Inc. ("AMR") seeks to dismiss the Plaintiff-Relator's Third Amended Complaint (the "TAC") for purportedly failing to identify "material detail about specific false claims allegedly submitted to the government, and the who, what, and where of the alleged frauds," as required by Fed. R. Civ. P. 9(b). *AMR Memo., p. 1.* As detailed below, the TAC sufficiently alleges numerous false claims by AMR. As such, AMR's motion to dismiss must be denied.

MATERIAL ALLEGATIONS

The TAC includes the following material allegations:

The Fraudulent Scheme

- Medicare and Medicaid only reimburse transport by ambulance that is "medically necessary" (TAC ¶¶ 2, 13-19).

- AMR (the nation's largest ambulance company) maintains a branch office in New Haven, Connecticut, where Paul Fabula ("Fabula") actively worked as an Emergency Medical Technician ("EMT") from August 2010 to December 25, 2011 (TAC ¶¶ 8-9).

- For every ambulance transport that Fabula performed during that 16-month period, a contemporaneous electronic Patient Care Report ("PCR") was generated which described the condition of the person being transported, and thus identified whether or not the transport was "medically necessary" so as to be reimbursable by Medicare or Medicaid (TAC ¶¶ 22-26).

- Fabula fully understood which of the ambulance runs that he performed for AMR comprised "medically necessary" transportation, and which did not, and the electronic PCRs that he prepared in the field accurately reflected whether or not a run was reimbursable under Medicare or Medicaid (TAC ¶ 27).

- Despite the accuracy of his field-generated PCRs, or rather because of their accuracy, Fabula frequently was required by AMR to alter his PCRs, or to create new ones (TAC ¶ 28).

- Specifically, AMR routinely provided Fabula, and all of the other EMTs and paramedics, with printouts of PCRs that they had prepared in the field (TAC ¶ 29).

- Those printouts would have handwritten revisions on them which altered the substance of the original electronic PCRs so as to re-describe medically unnecessary transports, as medically necessary runs (TAC ¶ 30).

- Under threat of suspension or termination, AMR's Director of Clinical Service (Jeffrey Boyd), its Operations Supervisor (Russell Pierson), and its Transportation Authorization Department Supervisor (Lindsay Martus), ordered Fabula, and all of the other EMTs and paramedics, to revise their field-created electronic PCRs to incorporate the handwritten changes, or to create entirely new electronic PCRs that included the false information reflected in the handwritten changes, so that AMR could obtain reimbursement for the medically unnecessary runs from Medicare and Medicaid (TAC ¶¶ 31-34, 38, 47, 51, 90).

- This process took place on a daily basis in the New Haven garage (TAC ¶¶ 37-38).

- Once the changes were made, the printouts with the handwritten changes were collected and shredded (TAC ¶¶ 36, 49).

- In 2011, in Fabula's presence, AMR's Director of Clinical Services, Boyd was asked whether the altering and creating of PCRs misrepresenting transports as

medically necessary was worth the effort, to which he responded: "Hey, it's working" (TAC ¶ 163).

Specifically Identifiable Transports Misrepresented As Medically Necessary

- Throughout the summer of 2011, in response to 911 calls, Fabula performed approximately 72 medically unnecessary transports of a diabetic man, John Conroy (since deceased), from his residence at 36 Helstrom Avenue in New Haven, Connecticut, to a medical facility where he obtained his daily dose of insulin (TAC ¶ 108).

- Throughout the summer of 2011 Fabula repeatedly performed medically unnecessary transports of a man, William Peagler, from a healthcare facility, Madison House, to a dialysis center, Branford Dialysis, for daily dialysis appointments (TAC ¶ 109).

- On July 7, 2011, in response to a 911 call, Fabula (and a paramedic, William Schick) performed a medically unnecessary transport of a woman (suffering from allergies) from a state housing facility in New Haven, Connecticut, to a hospital (the woman stated her belief that if she arrived to the hospital by ambulance, she would be able to "skip the line") (TAC ¶ 102).

- On July 7, 2011, in response to another 911 call, Fabula (and Paramedic Schick) performed a medically unnecessary transport of a man (in need of cough syrup) from a homeless shelter in New Haven, Connecticut, to a hospital (TAC ¶ 102).

- On December 7, 2011, Fabula (and an EMT, Douglas Gladstone) performed another medically unnecessary transport of Mr. Conroy (TAC ¶ 100).

- On December 14, 2011, in response to a 911 call, Fabula (and a paramedic, Amy Baitch) performed a medically unnecessary transport of a person from 195 Platt Street in Milford, Connecticut, to Milford Hospital (TAC ¶ 97).

- On December 14, 2011, in response to a 911 call, Fabula (and Paramedic Baitch) performed a medically unnecessary transport of a person from 225 Amity Road in Woodbridge, Connecticut, to Yale-New Haven Hospital (TAC ¶¶ 97-98).

- On December 16, 2011, Fabula transported a patient from New Haven, Connecticut, to Guilford, Connecticut, and to ensure that Medicare would pay the bill, AMR directed him to state in the PCR that the transport was medically necessary because the patient was unable to sit at a 90-degree angle due to a hip fracture, despite the fact that the cited hip fracture had occurred more than five years earlier, and the patient had fully recovered from it (TAC ¶ 96).

AMR's Compartmentalization of Its Business Processes in Furtherance of the Fraud

- As with all of AMR's EMTs and paramedics, Fabula was not involved in the actual submission of the fraudulent PCRs that he altered and created to Medicare and Medicaid. (¶¶ 115-116).

- That function was performed by personnel in a separate unit of AMR known as "TAD," which was located in a separate administrative building to which the EMTs and paramedics did not have access, and which was also overseen by Pierson (¶¶ 115-116).

The Fraud Is Extensive

- The improper altering and creating of PCRs misrepresenting transports as medically necessary was by no means limited to Fabula; indeed, Fabula witnessed all of his fellow EMTs and paramedics being subjected to the same scheme on a daily basis (TAC ¶¶ 111-112).

- Medicare (in response to a Freedom of Information Act request) has confirmed that AMR's New Haven branch had 344,867 transports paid for by Medicare or Medicaid for 2010 and 2011 (TAC ¶ 156).

- Consistent with his own experience during those years, Fabula estimates that only twenty-five percent (25%) of those transports were actually medically necessary (TAC ¶¶ 158-159).

ARGUMENT

A. The TAC's Allegations State Violations of the False Claims Act With Sufficient Particularity.

"Rule 9(b), Fed.R.Civ.P., requires that '[i]n all averments of fraud . . . the circumstances constituting [the] fraud . . . shall be stated with particularity' . . .," and "[i]t is well-settled . . . that Rule 9(b) . . . applies to FCA claims." *In re Cardiac Devices Qui Tam Litigation*, 221 F.R.D. 318, 332 (D. Conn. 2004). As *In re Cardiac Devices* further instructs:

> The Second Circuit has held that in order to satisfy the requirements of Rule 9(b), a plaintiff's 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 ***The purpose of the specificity requirement is to ensure that the complaint provides a defendant with fair notice of a plaintiff's claim and with adequate information to frame a response.***

Id. at 332-33 (internal citations omitted) (emphasis supplied).

Similar to the present matter, the relator in *In re Cardiac Devices* alleged that medical services were improperly billed to Medicare. More specifically, the relator "alleged that . . . hospitals had defrauded Medicare . . . by submitting claims and receiving payments for . . . services provided to patients . . . participat[ing] in clinical trials involving . . . cardiac devices that had not been approved for marketing by the [FDA]," and thus which were not considered to be "reasonable and necessary" so as to be compensable by Medicare. *Id.* at 323.

The defendant hospitals moved to dismiss the complaints against them. As in this case, the defendant hospitals contended that the allegations failed to satisfy Rule 9(b) because "[t]he complaints ***do not identify specific claims submitted to the Government*** and ***do not allege the 'who, what, when, and why' of the defendants' allegedly fraudulent misconduct.***" *Id.* at 332 (emphasis supplied).

In denying the motion to dismiss, the Court observed that the relator's complaints incorporated lists which identified the patients for whom false claims were purportedly submitted. *Id.* at 336. Consequently, the Court analyzed and concluded:

> [W]e find that the complaints satisfy the "who, what, where, when, and why" requirements of Second Circuit case law. The "who" in the complaints is the hospital.
>
> * * *
>
> The "what" is the submission of claims for procedures involving the . . . cardiac devices identified in the complaints for the patients identified in the lists . . . . The "where" is the place the claims and reports were filed, either with fiscal intermediaries, the state Medicaid office or elsewhere, facts that should be within the knowledge of the hospitals. The "when" of the false claim is sufficiently identified or ascertainable based upon the dates of the patients' hospitalizations . . . . The "how" of the alleged fraud is detailed in the portion of the complaints describing defendants' alleged wrongdoing, in which claims . . . were submitted and certified regarding procedures involving these . . . devices.

* * *

> [T]he defendants have been provided with fair notice of the substance of the claims against them. The complaints, read in conjunction with the patient lists provided to the hospitals, contain sufficient detail to accomplish the basic purposes of Rule 9(b).

Id. at 337-38; *cf.*, *Mooney v. Americare, Inc.*, No. 06-CV-1806 (FB)(VVP), 2013 WL 1346022 at *4 (E.D.N.Y. April 3, 2013) ("Defendants correctly assert that the Third Amended Complaint fails to plead with particularity the 'who, what, when, where and how' of the fraudulent referral scheme. [Relator] does not provide patient names . . . [or] dates of services . . . .") (internal citation omitted).

Applying this same rubric to the instant matter, it is readily apparent that the TAC's allegations plead the "who, what, where, when, and why" of false claims with sufficient particularity to satisfy the requirements, and purposes, of Rule 9(b). Clearly, the TAC identifies the "who" of the false claims – *i.e.*, AMR. *In re Cardiac Devices*, 221 F.R.D. at 337 ("The 'who' in the complaint is the hospitals.").

The TAC also identifies the "what" of the claims – *i.e.*, the submission of claims for payment for ambulance transports that were misrepresented as being "medically necessary," and thus compensable by Medicare or Medicaid. Indeed, the TAC alleges a multitude of specific transports that Fabula was directed to misrepresent as being "medically necessary," including:

- Numerous (approximately 72) transports of Mr. Conroy during the summer of 2011 (TAC ¶ 108).
- Another transport of Mr. Conroy on December 7, 2011 (TAC ¶ 100).
- Numerous transports of Mr. Peagler from Madison House to Branford Dialysis during the summer of 2011 (TAC ¶ 109).
- The transport of a person from 195 Platt Street in Milford, Connecticut, to Milford Hospital on December 14, 2011 (TAC ¶ 97).

- The transport of a person from 225 Amity Road in Woodbridge, Connecticut, to Yale-New Haven Hospital on December 14, 2011 (TAC ¶¶ 97-98).

- The transport of a man from New Haven, Connecticut, to Guilford, Connecticut on December 16, 2011 (TAC ¶ 96).

- The transport of a woman from a state housing facility in New Haven, Connecticut, to a hospital on July 7, 2011 (TAC ¶ 102).

- The transport of a man from a homeless shelter in New Haven, Connecticut, to a hospital on July 7, 2011 (TAC ¶ 102).

In identifying particular people (Mr. Conroy and Mr. Peagler) for whom ambulance transports were misrepresented as medically necessary, the TAC undeniably identifies the "what" of certain false claims with precision. *In re Cardiac Devices*, 221 F.R.D. at 337 ("The 'what' is the submission of claims for procedures involving the . . . cardiac devices identified in the complaints for the patients identified in the lists . . . ."). Certainly, such information provides AMR with fair notice of certain claims against it. *Id.* at 338 ("[T]he defendants have been provided with fair notice of the substance of the claims against them. The complaints, read in conjunction with the patient lists provided to the hospitals, contain sufficient detail to accomplish the basic purposes of Rule 9(b).").

Stated otherwise, the TAC provides AMR "with adequate information to frame a response" – again, which is the purpose of Rule 9(b). *Id.* at 332-33 ("The purpose of the specificity requirement is to ensure that the complaint provides a defendant with fair notice of a plaintiff's claim and with adequate information to frame a response."). More specifically, the TAC adequately apprises AMR that it must frame a response to the contention that Fabula was directed to misrepresent, as medically necessary, transports of Mr. Conroy during the summer of 2011, and on December 7, 2011. Similarly, the TAC adequately apprises AMR that it must frame a response to the contention that Fabula was directed to misrepresent, as medically

necessary, transports of Mr. Peagler during the summer of 2011. Along the same lines, the TAC adequately apprises AMR that is must frame a response to the contentions that Fabula was directed to misrepresent, as medically necessary: (i) the transport of a person from 195 Platt Street in Milford, Connecticut, to Milford Hospital on December 14, 2011; (ii) the transport of a person from 225 Amity Road in Woodbridge, Connecticut, to Yale-New Haven Hospital on December 14, 2011; (iii) the transport of a man from New Haven, Connecticut, to Guilford, Connecticut on December 16, 2011; (iv) the transport of a woman from a state housing facility in New Haven, Connecticut, to a hospital on July 7, 2011; and (v) the transport of a man from a homeless shelter in New Haven, Connecticut, to a hospital on July 7, 2011.

The TAC also identifies the "where" – *i.e.*, AMR improperly submitted false claims to Medicare and Medicaid. *In re Cardiac Devices*, 221 F.R.D. at 337 ("The 'where' is the place the claims and reports were filed, either with fiscal intermediaries, the state Medicaid office or elsewhere, *facts that should be within the knowledge of the hospitals*.") (emphasis supplied). Whether or not claims were submitted to Medicare or Medicaid for Fabula's transports of Mr. Conroy during the summer of 2011 (and on December 7, 2011), is well within the knowledge of AMR, and the same goes for Fabula's transports of Mr. Peagler during the summer of 2011. Likewise, AMR can readily ascertain whether it submitted claims to Medicare or Medicaid for those transports performed by Fabula on July 7, 2011; December 14, 2011; and December 16, 2011 (as detailed above).

The TAC also provides information from which the "when" of the false claims is readily ascertainable – *i.e.*, the occurrence dates of transports misrepresented as medically necessary. *In re Cardiac Devices*, 221 F.R.D. at 337 ("The 'when' of the false claim is sufficiently identified *or ascertainable* based upon the dates of the patients' hospitalizations.") (emphasis supplied).

Finally, the "how" of the fraud is also pled with particularity – *i.e.*, AMR's directing of Fabula (and other EMTs and paralegals) – through its Director of Clinical Service (Boyd), its Operations Supervisor (Pierson), and its Transportation Authorization Department Supervisor (Martus) – to alter or create PCRs indicating that medically unnecessary transports, were medically necessary, so that the transports could be billed to Medicare or Medicaid. *In re Cardiac Devices*, 221 F.R.D. at 337 ("The 'how' of the alleged fraud is detailed in the portion of the complaints describing defendants' alleged wrongdoing . . . .").

Where the TAC undeniably alleges numerous violations of the False Claims Act with sufficient particularity to satisfy the requirements and purpose of Rule 9(b), AMR's motion to dismiss the TAC must be denied. Indeed, as AMR concedes, dismissal of the TAC is inappropriate if its allegations sufficiently identify even a single false claim. *AMR Memo., p.10* (citing *Grenadyor v. Ukrainian Vill. Pharm., Inc.*, No. 09 C 7891, 2013 U.S. Dist. LEXIS 138232, at *15 (N.D. Ill. Sept. 26, 2013) for the proposition that "***pleading fraud with particularity requires providing at least one specific instance of wrongdoing that satisfied the who, what, where, when and how requirements of Rule 9(b).***") (emphasis supplied); *see also*, *U.S. ex rel. Bilotta v. Novartis Pharmaceuticals Corp.*, 50 F. Supp. 3d 497, 526 (S.D.N.Y. 2014) ("'[T]o satisfy Rule 9(b)'s particularity requirement and to enable [defendants] to respond specifically to [the relator's] allegations, [the relator] must provide *some* representative examples of their alleged fraudulent conduct . . . .'") (quoting *U.S. ex. rel. Joshi v. St. Luke's Hosp., Inc.*, 441 F.3d 552, 557 (8th Cir. 2006)) (italics in original).

B. AMR's Reliance Upon *Clausen* and Its Progeny Is Misplaced.

AMR relies heavily upon the case of *U.S. ex rel. Clausen v. Lab. Corp. of Am., Inc.*, 290 F.3d 1301, 1311 (11th Cir. 2002) as purported support for its motion to dismiss. However, a

review of that decision readily reveals that it is the product of materially differing circumstances than those existing in the present matter.

More specifically, the relator in *Clausen* was a *competitor* of the defendant corporation, and never had worked for the defendant corporation. 290 F.3d at 1302-03 ("Plaintiff . . . works in the medical testing industry . . . and identifies himself as a . . . competitor of LabCorp. He does not claim to have ever worked for LabCorp."). Thus, due to his status as a non-employee outsider, the plaintiff was simply unable to allege adequate reasons for his belief that false claims actually had been submitted. It is in that particular context that the *Clausen* Court stated that Rule 9(b) "does not permit a False Claims Act plaintiff merely to describe a private scheme in detail but then to allege simply ***and without any stated reason for his belief*** that claims requesting illegal payments must have been submitted, were likely submitted or should have been submitted to the Government." *Id.* at 1311 (emphasis supplied).

By contrast, the TAC *does* allege adequate reasons for Fabula's belief that false claims were actually submitted. Indeed, where the TAC alleges that AMR – through its Director of Clinical Service (Boyd), its Operations Supervisor (Pierson), and its Transportation Authorization Department Supervisor (Martus) – directed Fabula to alter and create PCRs misrepresenting transports as medically necessary, *so that the transports could be billed to Medicare or Medicaid*,[1] it alleges a specific basis for Fabula's belief that claims for those transports were submitted to Medicare or Medicaid. Moreover, the TAC alleges not only a basis for Fabula's belief that false claims were being submitted, but for his belief that those claims were being paid – *e.g.*, Boyd's express acknowledgment that the scheme was working.[2]

[1] *See, e.g.*, TAC ¶¶ 33, 38, 47, 51, 90, 96, and 108.

[2] TAC ¶ 163.

Another decision that AMR heavily relies upon, *U.S. ex rel. Kester v. Novartis Pharmaceuticals Corp.*, No. 11 Civ. 8196 (CM), 2014 WL 2619014 (S.D.N.Y. June 10, 2014), is no more applicable. The relator in *Kester* alleged that the defendant, a pharmaceutical company, gave rebates and discounts to certain pharmacies to induce them to "recommend" its drugs to doctors and patients, and that such conduct violated the federal Anti-Kickback Statute (AKS). *Id.* at *2. The relator further alleged that the violations of the AKS must have resulted in false claims being submitted by the pharmacies that received the kickbacks, because "compliance with the AKS is a precondition to payment of claims submitted to government programs." *Id.* at *3. In partially allowing the defendant's motion to dismiss, the *Kester* Court (citing *Clausen*) instructed that the plaintiff needed to "provid[e] a factual basis to support his assertion that claims were actually submitted to a government program," and found that "the Relator does not provide any factual basis to support his assertion that [the defendant] actually caused any pharmacy to submit claims for [certain of its drugs] to the government." *Id.* at *8. By contrast, once again, the TAC *does* provide a factual basis to support Fabula's assertion that AMR actually submitted false claims, namely, its allegations that Boyd, Pierson, and Martus directed him to alter and create PCRs misrepresenting transports as medically necessary, *so that the transports could be billed to Medicare or Medicaid.*[3]

Thus, where *Clausen* and *Kester* (and the array of other "kickback" cases that AMR cites) turn on fundamentally differing factual circumstances, they are of little (if any) value in assessing the adequacy of plaintiff's pleadings. *In re Cardiac Devices*, 221 F.R.D. at 338 ("[E]ach case must be considered on its own facts to determine whether the facts, as alleged, satisfy the underlying purposes of Rule 9(b). Rule 9(b) does not impose a 'one size fits all' list of facts that must be included in every FCA complaint."); *id.* at 333 ("It is only common sense

[3] *See, e.g.*, TAC ¶¶ 33, 38, 47, 51, 90, 96, and 108.

that the sufficiency of pleadings under Rule 9(b) may depend 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.") (internal quotations omitted).

C. The Circumstances Also Warrant a Less Stringent Application of the Rule 9(B) Standard.

As painstakingly detailed (Part A, *supra*), the TAC satisfies the pleading requirement of Rule 9(b). However, even were that not the case, dismissal of the TAC would still be inappropriate as the circumstances also warrant a less stringent application of the Rule 9(b) standard. In that regard, it is well settled that Rule 9(b)'s specificity requirement may be relaxed for matters peculiarly within the adverse party's knowledge. *Mooney*, 2013 WL 1346022 at *3 ("The Second Circuit applies a relaxed pleading standard when a plaintiff is not in a position to know specific facts until after discovery and 'when facts are peculiarly within the opposing party's knowledge.'") (quoting *Wexner v. First Manhattan Co.*, 902 F.2d 169, 172 (2d Cir. 1990)); *U.S. ex rel. Smith v. Yale Univ.*, 415 F. Supp. 2d 58, 83 (D. Conn. 2006) ("The general rule is that Rule 9(b) pleadings cannot be based on 'information and belief.' This rule may be relaxed, however, for matters peculiarly within the adverse parties' knowledge.") (internal citation and quotations omitted); *In re Cardiac Devices*, 221 F.R.D. at 334 ("Furthermore, courts have held that Rule 9(b)'s heightened pleading standard may be applied less stringently when the specific factual information is peculiarly within the defendant's knowledge or control."); *id.* at 333 ("Courts facing similar claims under the False Claims Act have not placed the bar so high as to require pleading with total insight.") (internal quotations omitted).

Furthermore, "[f]requently . . . in cases involving complex or extensive schemes of fraud, the courts have relaxed the pleading requirements of Rule 9(b)." *In re Cardiac Devices*, 221

F.R.D. at 333; *id.* (quoting *U.S. ex rel. Johnson v. Shell Oil Co.*, 183 F.R.D. 204, 206-07 (E.D. Tex. 1998) for the proposition that "[s]imilarly, it has been widely held that where the fraud allegedly was complex and occurred over a period of time, the requirements of Rule 9(b) are less stringently applied.").

The reasoning behind courts' willingness to apply a less stringent standard in these instances is readily grasped: "To approach the issue otherwise would allow the more sophisticated to escape liability under a False Claims case due to the complexity of their scheme and their deviousness in escaping detection." *In re Cardiac Devices*, 221 F.R.D. at 333 (internal quotations omitted).

Against this backdrop, whether or not AMR submitted claims to Medicare or Medicaid for Fabula's transports of Mr. Conroy during the summer of 2011 (and on December 7, 2011), for his transports of Mr. Peagler during the summer of 2011, or for the transports that he performed on July 7, December 14, and December 16 of 2011, is information peculiarly within AMR's knowledge and control.[4] Consequently, the relator-plaintiff may properly plead that AMR submitted claims for those transports on information and belief. Indeed, again, where the TAC alleges that AMR – through its Director of Clinical Service (Boyd), its Operations Supervisor (Pierson), and its Transportation Authorization Department Supervisor (Martus) – directed Fabula to alter or create PCRs misrepresenting transports as medically necessary, *so that the transports could be billed to Medicare or Medicaid*,[5] it alleges a specific basis for Fabula's belief that claims for those transports were submitted to Medicare or Medicaid. *See, e.g.*, *Smith*,

[4] In fact, as the TAC alleges, all of AMR's false claims based upon improper altering or recreating of PCRs can readily be identified by, and from, the existence of multiple versions of electronic PCRs for any particular transport that has been submitted to Medicare or Medicaid for payment – *i.e.*, information peculiarly with possession and control of AMR. TAC ¶¶ 110 and 114.

[5] *See, e.g.*, TAC ¶¶ 33, 38, 47, 51, 90, 96, and 108.

415 F. Supp. 2d at 83 (aspects of fraud may be pled upon information and belief if "the complaint sets forth the facts on which the belief is founded.") (internal quotations omitted). To find otherwise would be to allow AMR – by compartmentalizing its EMTs and billing personnel[6] – "to escape liability under a False Claims case due to the complexity of [its] scheme and [its] deviousness in escaping detection." *In re Cardiac Devices*, 221 F.R.D. at 333 (internal quotations omitted).

Moreover, where the TAC adequately provides AMR with notice of the claims against it, to require plaintiff to provide the specifics of the several hundred thousand false claims at issue[7] "would accomplish no purpose":

> Here, the defendants have been provided with fair notice of the claims against them. The complaints, read in conjunction with the patient lists . . . contain sufficient detail to accomplish the basic purposes of Rule 9(b). To require the [plaintiff] to provide the specifics of 9,848 claims in the complaints . . . would be cumbersome, unwieldy, and would accomplish no purpose. As the court noted in *United States ex. Rel. Johnson v. Shell Oil*, 183 F.R.D. at 207, "[s]uch a requirement would cause the complaint to be in the hundred[s] of pages, if not the hundreds of pounds."

Id. at 338.

Again, where the TAC alleges numerous violations of the False Claims Act with sufficient particularity under the circumstances, AMR's motion to dismiss the TAC must be denied.

D. The Retaliation Claim Has Not Been "Abandoned."

AMR takes the nonsensical position that Fabula's retaliation claim has been "abandoned" by the failure to attempt to re-plead it as part of the TAC. This Court previously dismissed the retaliation count (Count II) of the Second Amended Complaint with prejudice to refiling, and

[6] TAC ¶¶ 115-116.

[7] TAC ¶¶ 111-112, 156, and 158-159.

only granted the bankruptcy trustee, as substitute relator, leave to prosecute Count I, which he has done in the TAC. *U.S. ex rel. Fabula v. American Medical Response, Inc.*, No. 3:12-cv-921 (MPS), 2015 WL 927548 at *10 (D. Conn. March 4, 2015).

CONCLUSION

The Third Amended Complaint is pled with sufficient particularity to permit AMR to understand the nature of, and to respond to, the false claims alleged against it. AMR's motion to dismiss seeks to leverage the compartmentalization of its scheme to defraud the United States by concealing from the employees who are compelled to fabricate the PCRs, the billing and payment information reflecting the profits that AMR improperly reaps from its false claims.

WHEREFORE, for this reason, and those set forth above, the Defendant's motion to dismiss must be denied.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on June 8, 2015, a copy of the foregoing Motion for Substitution of Party was served via ECF on all counsel of record.

/s/ Anthony R. Zelle
Anthony R Zelle

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

UNITED STATES ex rel. RONALD I. CHORCHES, Bankruptcy Trustee, Bringing this action on behalf of THE UNITED STATES OF AMERICA, the ESTATE OF PAUL FABULA, and PAUL FABULA, Individually, Plaintiff-Relator, v. AMERICAN MEDICAL RESPONSE, INC., Defendant.	Civil Action No. 3:12-CV-921 MPS June 22, 2015

DEFENDANT'S REPLY IN FURTHER SUPPORT OF MOTION TO DISMISS THE THIRD AMENDED COMPLAINT

Defendant American Medical Response, Inc. ("AMR") submits this Reply in further support of its Motion to Dismiss the Third Amended Complaint ("TAC").

1. Relator Concedes He Does Not And Cannot Identify Any False Claims Submitted; The TAC Therefore Does Not Satisfy Rule 9(b). Relator fails to plead the submission of any false claims at all, much less with the specificity required by Rule 9(b). In fact, Relator again admits that "Fabula was not involved in the actual submission of the fraudulent PCRs that he altered and created to Medicare and Medicaid." Plaintiff-Relator's Opposition to Defendant's Motion to Dismiss the Third Amended Complaint ("Opposition" or "Opp.") at 4; *see also* TAC ¶ 115. His allegations therefore still amount to nothing more than improper claims "must have been submitted, were likely to be submitted, or should have been submitted." *U.S. ex rel. Clausen v. Lab. Corp. of Am. Inc.*, 290 F.3d 1301, 1311 (11th Cir. 2002); *U.S. ex re. Kester v. Novartis Pharmaceuticals Corp.*, No. 11 Civ. 9816 (CM), 2014 U.S. Dist.

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LEXIS 81180, at *24 (S.D.N.Y. June 10, 2014). This is fatal to the TAC. *See* AMR Br. at 3-6; *see also* Mem. at 13-14, 18-22.[1]

Relator never actually alleges with specificity that AMR sought reimbursement or was reimbursed for a single one of the transports or PCRs he identifies in the TAC. Even if he pleaded these example *transports* (*i.e.*, a fraudulent scheme) with the specificity required by Rule 9(b), which he does not (*see* Point 4, *infra*), this does not satisfy Relator's additional, independent obligation to plead with particularly any *false claims* submitted to the government. Rule 9(b) requires that *all* essential elements of a cause of action must be pleaded with particularity, including, in FCA actions, false claims. *See, e.g., Kester*, 2014 U.S. Dist. LEXIS 81180, at *16-17; AMR Br. 3-6.

2. Relator's Argument Is Not Supported By The Precedent He Cites. Relator's reliance on *In re Cardiac Devices Qui Tam Litigation*, 221 F.R.D. 318 (D. Conn. 2004) is misplaced. Opp. 4-9. The complaints there identified the total number of claims allegedly improperly reimbursed by Medicare for each defendant for cardiac devices used in clinical trials. *Id.* at 330. No total number of claims or any comparable specificity is offered in the TAC. In addition, the complaints in that case were accompanied by lists of the specific false claims that each defendant had submitted and for which each defendant had received reimbursement. *Id.* at 330, 336. In contrast, Relator here alleges (without specificity) only that certain transports took place and that amendments to PCRs were made, not that those transports and amendments resulted in claims that were improperly submitted and paid. Therefore, the "what" identified in

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[1] AMR's Memorandum in Support of Defendant's Motion to Dismiss the Third Amended Complaint (Dkt. 77) is cited as "AMR Br"; AMR's Memorandum in Support of its *prior* Motion to Dismiss Relator's Second Amended Complaint (Dkt. 40) is cited as "Mem."; and AMR's *prior* Reply in Support of its Motion to Dismiss the Second Amended Complaint (Dkt. 59) is cited as "Reply."

In re Cardiac Devices—"the submission of claims for procedures"—is absent from the TAC here. *Id.* at 337.

Other cases relied upon by Relator similarly pled far more detail than Relator pleads here. In *U.S. ex rel. Mooney v. Americare, Inc.*, No. 06-CV-1806 (FB) (VVP), 2013 U.S. Dist. LEXIS 48398 (E.D.N.Y. Apr. 3, 2013), the relator alleged two different schemes, a kickback scheme and a fraudulent alteration scheme. *Id.* at *10. With regard to the kickback scheme, the relator identified 16 claims by start and end date, including referral sources; nonetheless, the court still granted the defendant's motion to dismiss because this lacked "key details" and therefore did not satisfy Rule 9(b). *Id.* at *15-16. In contrast, the relator alleged the fraudulent alteration scheme, which survived a Rule 9(b) challenge, "in much greater detail," including the people involved, the precise manner in which the claims were altered, the service dates, and the dates the claims were submitted. *Id.* at *21. In *U.S. ex rel. Bilotta v. Novartis Pharmaceuticals Corp.*, 50 Supp. 3d 497 (S.D.N.Y. 2014), the government's complaint-in-intervention included 316 pages of spreadsheets that listed the allegedly false or fraudulent claims submitted for reimbursement, including, *inter alia*, the prescribing doctor, the drug, the government program to which the claims was submitted, the date the prescription was filled, the cost, and the date the claim was processed and paid. *Id.* at 506, 521.

In *U.S. ex re. Smith v. Yale University*, 415 F. Supp. 2d 58 (D. Conn. 2006), the court found that the complaint likely provided the defendant with adequate notice of the claims against it, but still dismissed on Rule 9(b) grounds because, "[w]ithout a description of any actual fraudulent billing, Defendant [would be] forced to search its records for evidence to prove it did not commit fraud, releasing Relator from the burden of proving fraud was actually committed[.]" *Id.* at 88. Here, as in *Smith*, Relator is seeking a ticket to discovery without having pleaded the

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heart of his action—an actual false claim. This is exactly the type of suit Rule 9(b) seeks to prevent.

Relator's attempts to distinguish *Clausen* and *Kester* fail. Opp. at 9-11. Relator is incorrect that the purported specific instructions from Boyd, Pierson, and Martus to revise PCRs so that transports could be billed are sufficient. In fact, the statements actually attributed to Boyd, Pierson, and Martus, are innocuous, and very few of them reference billing at all. *See, e.g.,* TAC ¶¶ 52-53, 128, 134; Mem. at 17-18 n.18.

Relator is therefore not relying on actual instructions from AMR employees as the basis for his belief that claims were submitted, but instead on his own understanding of what those statements meant. Relator's interpretations of statements are conclusions, not the type of facts required to satisfy Rule 9(b). *See, e.g., Kester*, 2014 U.S. Dist. LEXIS 81180, at *18 (to satisfy 9(b) a relator must "provid[e] a factual basis (as opposed to mere speculation) to support the plaintiff's assertion that claims were actually submitted to a government program."). The few instances where Relator does identify a statement by someone at AMR that mentions billing—e.g. "Medicare is not paying…the way you have it written"—are again devoid of facts that would indicate Medicare ever received the claim and thereafter reimbursed for these runs at all, much less that they were improperly reimbursed. *See, e.g.,* TAC ¶ 39. Such statements are entirely innocuous on their face and consistent with maximizing legitimate reimbursements, which is not fraud. *See* Mem. at 14; AMR Br. at 14-15.

Similarly, Relator's repeated reference to an alleged statement by Boyd that "it's working" – referring to the new way of completing PCRs – is to no avail. Opp. at 2-3, 10; TAC ¶ 163. This is not evidence that Medicare was being billed at all, let alone improperly, just that the training was effective and personnel were writing better PCRs. Relator has alleged nothing

to connect this statement to any improper conduct except for Relator's speculation that "better" meant "billable." TAC ¶ 128. Significantly, Relator never alleges anyone at AMR ever told him "better" meant "billable," only that this is what he "understood" this to mean. TAC ¶ 134. Once again, Relator takes an innocuous statement regarding improving paperwork and attempts to twist it into fraud. *See* AMR Br. at 15. Again, speculative allegations that claims "must have been submitted, were likely to be submitted, or should have been submitted," do not satisfy Rule 9(b). *Clausen*, 290 F.3d at 1311; *Kester*, 2014 U.S. Dist. LEXIS 81180 at *24.

3. A Relaxed Pleading Standard Should Not Be Applied. Recognizing that he cannot satisfy Rule 9(b)'s heightened pleading standard, Relator argues that this standard should be relaxed because billing information is "peculiarly within AMR's knowledge and control." Opp. at 13. Relator is not entitled to, nor would he satisfy, a relaxed pleading standard.

Relator fails to distinguish or even address the determination in *Corporate Compliance Associates* that where a relator fails to plead details regarding any false claims submitted, "[i]t is not a satisfactory answer that [relator] lacks the information to address" that issue. *U.S. ex rel. Corp. Compliance Assocs. v. N.Y. Society for the Relief of the Ruptured and Crippled*, No. 07 Civ. 292 (PKC), 2014 U.S. Dist. LEXIS 109786, at *50 (S.D.N.Y. Aug. 7, 2014), cited in AMR Br. at 6.

Moreover, Relator's case law discussing a relaxed standard for a complex or long running scheme is irrelevant. Opp. at 12-13. Although where an FCA action involves a large number of claims or instances of fraud, it is sufficient to plead by example and a relator need not identify *every single* claim submitted, Relator here has not pled by example. To the contrary, *he has not identified a single false claim* for payment actually submitted to the government and admits he has no knowledge of any particular claims submitted. Opp. at 4. Relator also fails to respond to

AMR's observation that he largely fails to even allege that the few patients he identifies were Medicare or Medicaid recipients at all, yet another reason the TAC does not satisfy Rule 9(b). *See* AMR Br. at 8. Relator does not justify application of a relaxed standard.

Nor could Relator meet the standard were it to be applied. As AMR has noted, this case is similar to *Johnson v. The Univ. of Rochester Med. Ctr.*, 686 F. Supp. 2d 259 (W.D.N.Y. 2010); *see* AMR Br. at 7-8. In *Johnson*, the relator's supervisor advised her that paperwork could not be billed without certain items included and then alleged that the defendant engaged in a fraudulent scheme to include those items on its paperwork and improperly bill Medicare. 686 F. Supp. 2d at 267. However, the *Johnson* relator failed to identify specific bills or submission to Medicare and the complaint therefore failed to satisfy Rule 9(b). The same result is warranted here. *Johnson* is on point authority to which Relator simply fails to respond.

Moreover, Relator's allegations fail even applying the precedent he cites. Opp. at 12-13 (citing cases). *Mooney* refused to apply a relaxed 9(b) standard and so is not relevant for assessing whether Relator's claims satisfy such a relaxed standard. 2013 U.S. Dist. LEXIS 48398, at *16-17. *Smith* held that to satisfy a relaxed Rule 9(b) standard a complaint must identify and include details of specific examples of claims submitted for payment. 415 F. Supp. 2d at 87 ("If Relator is unable to identify a single false claim arising from the alleged scheme of fraud or at least set forth an adequate basis on which his belief is based, he cannot meet even a bare-bones Rule 9(b) test.") (internal quotation marks and quoting reference omitted). *Smith* therefore dismissed the claims where the relator failed to provide, *inter alia,* examples of false claims, amounts of false claims, or dates false claims were submitted. *Id.* Relator cannot satisfy even the relaxed 9(b) standard he advocates for.

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4. Relator Does Not Plead False or Fraudulent Conduct with Specificity, and No Relaxed Standard Applies To Alleging a Fraudulent Scheme. Relator continues to assert that the isolated details in the TAC regarding various *different* runs satisfy Rule 9(b). They do not. Relator must allege the who, what, where, when, and how of at least one particular instance of fraud, not a combination of one or two of these items for multiple different instances.[2] *See* AMR Br. at 9-15 (explaining why the examples cited by Relator in the TAC are insufficient). Relator does not even address many of these issues in the Opposition.[3] Most notably, Relator does nothing to defend the centerpiece of his allegations—the PCR he was allegedly asked to complete from December 2011 that he claims formed the basis for his termination. Relator also fails to address numerous other examples challenged by AMR, instead hinging his ever-shrinking case on only a few partial examples. Opp. at 6-7. None of these examples satisfy Rule 9(b). AMR Br. 11-14. Relator does not even attempt to refute AMR's arguments that he fails to allege necessary details of the examples, instead merely reasserting without support that these examples sufficiently allege his scheme and restating his "notice" mantra to argue that these incomplete examples suffice. Opp. at 6-8. They do not. AMR Br. 11-14.

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[2] Contrary to Relator's assertion, AMR's reference to *U.S. ex rel. Grenadyor v. Ukrainian Vill. Pharm., Inc.*, No 09 C 7891, 2013 U.S. Dist. LEXIS 138232 (N.D. Ill. Sept. 26, 2013) is not a "concession" that the TAC survives if it sufficiently identifies a *single* instance of fraud with particularity. Opp. at 9. *Grenadyor* does not set forth a strict rule that one example is always enough, just that there must be "*at least one specific instance*" alleged to satisfy Rule 9(b). *Grenadyor*, 2013 U.S. Dist. LEXIS 138232, at *15 (emphasis added). More importantly, Relator here has failed to allege a single instance with particularity—*i.e.* the who, what, where, when, and how—instead alleging the who of one instance, the what of another, the where of a third, and so on. *See* AMR Br. at 9-15.

[3] Of particular note, Relator does not respond to AMR's arguments that Relator's anecdotes of types of patients (e.g. needing assistance, hip replacements, dementia, unsteady gait or poor balance, fall risks, and unable to regulate their own oxygen) do not satisfy Rule 9(b). AMR Br. at 13 n.11. Relator also does not dispute AMR's argument that his cursory allegations regarding physician certification statements, paramedic assessments, and indications that patients were bed confined do not plead the essential elements of a cause of action at all, much less with the specificity required by Rule 9(b). *Id.* at 15 n.14.

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Recognizing that he has not pleaded sufficient details with particularity, Relator again resorts to arguments that he should be afforded a relaxed 9(b) standard and that he has given AMR adequate notice. But there is no relaxed pleading standard for pleading a fraudulent scheme, as opposed to claims. *See, e.g., U.S. ex rel. Klein v. Empire Educ. Corp.*, 959 F. Supp. 2d 248, 257 (N.D.N.Y. 2013) (even where Rule 9(b) relaxed as to submission of claims, fraudulent scheme must be pled in detail). Relator plainly and simply fails to state a claim.

5. Dismissal Is Consistent with the Purposes of Rule 9(b). Contrary to Relator's sole focus that Rule 9(b) is intended to provide notice to a defendant, Opp. at 4, 7,[4] the Rule actually serves *three* main purposes: (1) providing a defendant with fair notice of a plaintiff's claims, (2) safeguarding a defendant's reputation from spurious charges of wrongdoing, and (3) preventing strike suits and discouraging the filing of complaints as pretexts for unknown wrongs. *Wood ex rel. United States v. Applied Research Assocs., Inc.*, 328 Fed. Appx. 744, 747 (2d Cir. 2009); *Mooney*, 2013 U.S. Dist. LEXIS 48398, at *6. Dismissal here is in accord with all of these purposes.

First, the TAC does not even satisfy the first goal of Rule 9(b) as it does not give AMR adequate notice of the claims against it. AMR cannot investigate Relator's claims by simply looking at run forms to see whether there are amendments to PCRs as indicia of fraud because run forms are amended for various legitimate reasons. *See* Reply at 6. As for the supposed "examples" in the TAC, Relator does not plead adequate details of a single alleged instance of fraud or falsified PCR, instead alleging a detail here and there for multiple examples without

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[4] Relator purports to rely on *In re Cardiac Devices* to support his argument that notice is all that is required to fulfil Rule 9(b)'s purpose. Opp. at 4 (quoting *In re Cardiac Devices*, 221 F.R.D. at 332-33). However, Relator omits the very next sentence of *In re Cardiac Devices,* which states the two additional purposes of the Rule 9(b). 222 F.R.D. at 333. The other cases cited by Relator similarly reflect all three purposes, and that notice alone is insufficient to satisfy the Rule. *See* Opp. at 4-9.

pleading all details for any single example. *See* Point 4, *supra*. Each instance identified by Relator is missing part of the information AMR would need to investigate the claim, including the patient identifier, other AMR personnel, date, location, content, or explanation of what on the PCR is supposedly incorrect. AMR Br. at 9-15.

Secondly, the goals of safeguarding a defendant's reputation from spurious charges of wrongdoing and preventing strike suits are "equally strong." *Clausen*, 290 F.3d at 1313 n.24. Courts therefore readily recognize that notice alone does not satisfy Rule 9(b) and that the other purposes of 9(b) must be satisfied as well. *See, e.g., Smith*, 415 F. Supp. 2d at 88 (D. Conn. 2006) (noting that "[a]lthough the complaint may provide Defendants with adequate notice of the claims against it, Rule 9(b) has other purposes that must also be considered" and dismissing on Rule 9(b) grounds "[i]n light of these multiple purposes"); *Clausen*, 290 F.3d at 1312 n.21 ("when a plaintiff does not specifically plead the minimum elements of their allegation, it…may needlessly harm a defendant's goodwill and reputation by bringing a suit that is, at best, missing some of its core underpinnings, and, at worst, are baseless allegations used to extract settlements."); *Kester*, 2014 U.S. Dist. LEXIS 81180, at *24 (Rule 9(b) forbids speculation as to claims submitted "since its purposes include safeguarding defendants' reputations from improvident charges of wrongdoing, protecting defendants from strike suits, and discouraging the filing of suits as a pretext for the discovery of unknown wrongs."). Here, as in *Smith*, *Clausen*, *and Kester*, Relator is seeking a ticket to discovery without alleging the core of an FCA violation: a false claim. This is exactly the type of suit Rule 9(b) seeks to prevent.

6. Relator No Longer Seeks To Pursue A Nationwide Case. Relator does not dispute that the TAC involves only conduct in Connecticut, not nationwide conduct, demonstrating that the nationwide claims are no longer at issue. AMR Br. at 16; *see also In re UBS AG Securities*

Litig., No. 07 Civ. 11225 (RJS), 2012 U.S. Dist. LEXIS 141449, at *69 n.19 (S.D.N.Y. Sept. 28, 2012) (when a plaintiff fails to respond to defendants' arguments in his opposition to a motion to dismiss he "has conceded the point by silence.").

7. Fabula Abandons His Retaliation Claim In The TAC. AMR's observation that Fabula "abandoned" his retaliation claim is completely accurate. Relator's argument to the contrary references the March 4, 2015 Order dismissing the retaliation claim with prejudice (Dkt. 67), Opp. at 14-15, but ignores that the Court gave Relator leave to replead in its April 3, 2015 Order, stating "the Court will allow Plaintiffs the opportunity to amend both counts of the second amended complaint." Dkt. 75. In any event, it is clear that (1) Fabula has not repleaded his retaliation claim and (2) as the Court identified in the March 4, 2015 Order, Relator would not be able to plead additional facts to avoid dismissal at any rate. The retaliation claim therefore remains appropriately dismissed.

CONCLUSION

For the foregoing reasons and those set forth in AMR's Memorandum in Support of Defendant's Motion to Dismiss the Third Amended Complaint (Dkt. 77) as well as AMR's prior Memorandum and Reply in support of its Motion to Dismiss the Second Amended Complaint (Dkt. 40, 59), AMR respectfully requests that this Court grant its Motion to Dismiss and dismiss the Third Amended Complaint in its entirety and with prejudice.

Oral Argument Requested

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Oral Argument Requested

CERTIFICATE OF SERVICE

I hereby certify that on June 22, 2015, a copy of foregoing Defendant's Reply in Further Support of Motion to Dismiss the Third Amended Complaint was filed electronically and served by mail on anyone unable to accept electronic filing. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system or by mail to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing. Parties may access this filing through the Court's CM/ECF System.

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Dated: June 22, 2015

Oral Argument Requested

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

United States ex rel. RONALD I. CHORCHES, Bankruptcy Trustee, Bringing this action on behalf of THE UNITED STATES OF AMERICA, the ESTATE OF PAUL FABULA, and PAUL FABULA, Individually Plaintiff-Relator v. AMERICAN MEDICAL RESPONSE, INC., Defendant.	No. 3:12-cv-921 (MPS)

MEMORANDUM AND ORDER

Plaintiff-Relator Ronald Chorches, trustee of the bankruptcy estate of Paul Fabula, brings this action under the False Claims Act ("FCA"), 31 U.S.C. § 3729 *et seq.*, against Defendant American Medical Response, Inc. ("AMR"). The Third Amended Complaint (the "TAC") alleges that AMR, an ambulance company, violated the FCA by making false statements and submitting false claims to the government for reimbursement under the Medicare and Medicaid programs. (TAC, ECF No. 76.) AMR has moved to dismiss the TAC for failure to state a claim upon which relief can be granted under Federal Rule of Civil Procedure 12(b)(6) and for failure to plead fraud with particularity under Federal Rule of Civil Procedure 9(b).

The standard adopted by most district courts in this Circuit for pleading FCA claims requires particularity not only in alleging a fraudulent scheme, but also in alleging the actual submission of requests for payment, or "claims," to a government payor. The TAC does not meet this standard, as it pleads no factual detail regarding actual requests for payment submitted to the government. There is no specification of invoice numbers, invoice dates, or amounts billed or

reimbursed. In short, the TAC alleges no facts indicating that the medically unnecessary ambulance services it describes were actually billed to a government payor. For these reasons and others set forth below, AMR's motion to dismiss is GRANTED.

I. BACKGROUND

A. Procedural History

On June 22, 2012, Fabula filed this *qui tam* action under seal (ECF No. 1) as a relator on behalf of the United States. On September 27, 2013, the United States gave notice that it was declining to intervene. (Government's Notice of Election to Decline Intervention by USA, ECF No. 18.) The United States amended its notice on November 1, 2013 (ECF No. 22), and the Court ordered the Complaint unsealed on November 7, 2013. (Order, ECF No. 24.) Fabula filed his second amended complaint ("SAC"), bringing claims under the False Claims Act, 31 U.S.C. § 3729(a)(1) and 3729(a)(2) (Count One) on March 5, 2014. (SAC, ECF No. 39 ¶¶ 125-126.) Fabula also brought a claim for retaliation in violation of 31 U.S.C. § 3730(h) (Count Two). (*Id.* ¶¶ 131-41.)

AMR moved to dismiss the first count of the SAC for lack of subject matter jurisdiction, arguing that Fabula lacked standing to pursue his FCA claims because they belonged to his bankruptcy estate. (ECF No. 40-1 at 8-10.) AMR also argued that Fabula failed to plead his FCA claims with particularity as required by Fed. R. Civ. P. 9(b). (*Id.* at 11-24.) Finally, AMR argued that the second count, Fabula's FCA retaliation claim, failed to state a claim on which relief can be granted. (*Id.* at 30-32.) On March 4, 2015, the Court granted AMR's motion to dismiss Count One, finding that Fabula had lost any personal interest he had in pursuing the claim. The Court stayed this portion of its ruling for thirty (30) days to allow the bankruptcy trustee to appear and prosecute Fabula's claims. (ECF No. 67 at 19). The Court also granted AMR's motion to dismiss Count Two, Fabula's retaliation claim. (*Id.*) Chorches, the trustee for Fabula's bankruptcy estate,

appeared and moved to join the case on March 23, 2015 (ECF Nos. 68-70), and the Court granted the motion for joinder on April 2, 2015. (ECF No. 73.) On April 24, 2015, Chorches filed the TAC (ECF No. 76), which repleads Count One—the alleged making of false statements and false claims in violation of the FCA—but not Count Two—the retaliation claim. Because Chorches makes no attempt to replead the retaliation claim, that claim is dismissed with prejudice.[1] On May 11, 2015, AMR moved to dismiss the TAC. (ECF No. 77.)

B. Relevant Facts

According to the TAC, AMR is the largest ambulance company in the country. (TAC at ¶ 8.) Fabula worked as an Emergency Medical Technician ("EMT") in AMR's New Haven, Connecticut, branch office from August 2010 until December 25, 2011. (*Id.* ¶ 9.) Fabula's job as an EMT involved performing emergency and non-emergency medical transport services in New Haven, Fairfield County, Greater Hartford/Northeast Connecticut, and Waterbury/Farmington Valley. (*Id.* ¶¶ 9-11.)

The TAC alleges that AMR has (1) "knowingly presented or caused false records or statements to be presented to the United States for the purpose of getting a false or fraudulent claim paid or approved by the Government, in violation of 31 U.S.C. § 3729(a)(1)" and (2) "knowingly made, used or caused to be made or used false records or statements material to false or fraudulent claims to the United States for the purpose of getting false or fraudulent claims paid by the United States in violation of 31 U.S.C. § 3729(a)(2)."[2] (*Id.* ¶¶ 193-94.) Specifically,

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[1] On April 3, 2015, the Court issued an order permitting the plaintiff to replead both Count One and Count Two of the SAC. (ECF No. 75.) As noted, the plaintiff has chosen to replead only Count One.

[2] These subsections were amended by the Fraud Enforcement and Recovery Act of 2009 ("FERA") Pub. L. No. 111-21, § 4(a), 123 Stat 1617, 1621. As amended, they make liable any person who "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval," 31 U.S.C. § 3729(a)(1)(A), or "knowingly makes, uses, or causes to be made or used, a false record or

Chorches alleges that "AMR knowingly, systematically, and/or with willful disregard submitted claims for payment for ambulance transports that failed to meet Medicare and Medicaid coverage criteria with regard to medical necessity, and thus submitted false claims in violation of the False Claims Act." (*Id.* ¶ 195.)

Medicare, a federal health insurance program for people ages 65 and older, and certain others, *see* 42 U.S.C. § 1395c, does not reimburse AMR for ambulance transports (*i.e.* "runs") that are not "medically necessary." (TAC ¶ 13.) "[M]edical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated." (*Id.* at ¶ 15.) "[I]n any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services." (*Id.*) The Medicare Benefit Policy Manual provides that "payment is based on the level of services furnished (provided they were medically necessary), not simply on the vehicle used. Even if a local government requires an ALS [Advanced Life Support] response for all calls, payment . . . is made only for the level of service furnished, and then only when the service is medically necessary." (*Id.* ¶ 17 (*citing* Medicare Benefit Policy Manual §10.2.2.).) Thus, in order to receive reimbursement from Medicare, AMR was "required to review and submit information about the condition of patients, and the emergency or non-emergency medical services [it] provided" during transports. (*Id.* ¶ 173.)

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statement material to a false or fraudulent claim." *Id.* § 3729(a)(1)(B). Paragraph 167 of the TAC correctly cites these amended provisions.

Each time AMR dispatched an ambulance to transport someone, the participating paramedics and EMTs were required to complete an electronic Patient Care Report ("PCR").[3] (*Id.* ¶ 23.) Paramedics and EMTs included the following information in PCRs: the date, time, and address of the pickup; the name of the person being transported; the name of the medical facility to which the person was transported; and a description of the condition of the person being transported. (*Id.* ¶¶ 25-26.) The TAC alleges that the description of the transported person's condition identifies whether a run is "medically necessary," and thus reimbursable by the federal government. (*Id.* ¶ 26.) According to the TAC, "AMR was not in the habit of training its employees – Fabula and others – to recognize medical conditions in a patient that would require and qualify the patient for an ambulance for safe travel, or teach proper documentation for billing and patient care accuracy." (*Id.* ¶ 126.) Despite this lack of training, Fabula "fully understood which of the ambulance runs that he performed for AMR comprised 'medically necessary' transportation . . . and the electronic PCRs that he prepared . . . accurately reflected whether or not a run was reimbursable under Medicare." (*Id.* ¶ 27.)

1. General Allegations

The TAC alleges that AMR often required paramedics and EMTs, including Fabula, to "revise" or "recreate" PCRs. (*Id.* at 28-29.) Specifically, AMR supervisors "made ambulance personnel come back to the office to redo paperwork, saying that the 'run form' did not 'meet company standards' (translation: Medicare wouldn't pay). . . . And so the real meaning behind redoing the paper work was this: 'This run is not billable to Medicare, so if you know what's good for you, you'll come back and redo it so it is.'" (*Id.* ¶ 52-53, 92.)

[3] It is not clear from the TAC whether Medicare required a PCR, or whether it was required only by AMR.

AMR supervisors could not make changes to the PCRs themselves because the paramedics and EMTs had the unique log-in passwords that were required to complete electronic PCRs. (*Id.* ¶ 48.) Therefore, AMR supervisors hand-wrote changes onto printouts of PCRs that "altered the substance of the original electronic PCRs so as to re-describe medically unnecessary runs[] as medically necessary runs." (*Id.* ¶¶ 29-30.) AMR then forced paramedics and EMTs to make such changes to the electronic PCRs "under threat of suspension or termination." (*Id.* ¶¶ 33-34.) Even "when medical treatment was not required, AMR nonetheless required its employees, under threat of discontinuing their employment, to change the PCRs to qualify for Medicare reimbursement." (*Id.* ¶ 47.)

The supervisors who ordered these changes—directly or through their subordinates—included Jeffrey Boyd (Director of Clinical Service), Russell Pierson (Operations Supervisor), and Lindsay Martus (Transportation Authorization Department Supervisor). (*Id.* ¶ 32.) Each day, when the paramedics and EMTs punched in and out before and after their shifts, the supervisors gave them "paperwork that needed to be 'redone,' with notes providing instructions as to how the PCRs should be modified and changed with false information . . . ." (*Id.* ¶ 38.)

After the paramedics and EMTs made the changes to the electronic PCRs, AMR shredded the printouts containing the handwritten changes. (*Id.* ¶ 36, 49.) The TAC alleges that the purpose of the changes was "to qualify the run for Medicare reimbursement." (*Id.* ¶ 33.) The TAC further alleges that "the false claims based upon improper revising or recreating of . . . PCRs can be readily identified by, and from, the existence of multiple versions of electronic PCRs for any particular run that has been submitted to Medicare for payment – *i.e.*, information within the possession, custody, or control of AMR," (*id.* ¶ 110, 114) and its billing department known as "TAD." (*Id.* ¶ 116.)

The TAC describes, in general terms, the types of changes that AMR personnel made to PCRs. For example, Medicare would reimburse the transport of a patient with dementia only if the patient had a medical history of violence. (*Id.* ¶ 39.) Although approximately 40% of AMR's calls were for patients that suffered from dementia or Alzheimer's disease, "very few of these . . . patients actually met Medicare's requirements for an ambulance." (*Id.*) Therefore, the TAC alleges that "AMR supervisors routinely, on a daily basis . . . informed the EMTs, when they were being ordered to change the PCR forms, that 'Medicare is not paying for the dementia patient the way you have it written.'" Under threat of adverse employment action, EMTs "were routinely required to change the histories with Alzheimer's patients – so that the history included in the PCR a component of 'violence' – in order to qualify for Medicare." (*Id.*)

The TAC further alleges that when patients' recent medical histories did not provide a medically necessary reason for an ambulance transport, AMR employees were encouraged to call the dispatch center, located in New Haven, Connecticut, which kept "patients' histories and records from all across Connecticut on file." (*Id.* ¶ 86.) "The Dispatch Center then looked into the patient's past history to find a past reason for the transport, one that would qualify for Medicare reimbursement." (*Id* ¶ 87.) For example, Fabula called dispatcher Tom DellaValle to determine a "medical necessity reason" why a particular patient needed an ambulance. "DellaValle, being a dispatcher who had access to the patient's records, said, 'Well, she had a hip fracture three years ago.' So Fabula wrote on the PCR form, 'Hip fracture,' as though it had just occurred, and, on information and belief, the run was processed for Medicare reimbursement." (*Id.* ¶ 105.)

In addition to PCRs, the TAC alleges that AMR employees falsified Physician Certification Statements ("PCSs"), which are forms that "Medicare regulations require

physicians or registered nurses to complete." (*Id.* ¶ 54.) Often, "the AMR employee at the hospital filled out the PCS forms for the nurses, and then led the nurses to believe they were signing a form solely for AMR's record-keeping," when in fact "the forms they were signing were being submitted to Medicare." (*Id.*) "When AMR ambulance personnel could not find a reason why the patient needed to go by ambulance . . . the liaison person at the hospital (the AMR employee) looked into that person's medical history in order to find a reason why that person needed an ambulance, and he or she instructed the nurse on what needed to be written in the PCS."[4] (*Id.*)

2. Detailed Allegations

The TAC also describes certain runs in more detail, providing the names of patients and AMR employees, the dates and locations of transports, and some specific facts suggesting a fraudulent scheme. For example, the TAC alleges that two months after a run on December 4, 2011, Fabula was ordered "to come into the office and . . . input information electronically in order to falsify a PCR." (*Id.* ¶ 56, 71.) On the run in question, Fabula had assisted paramedic Kevin Bodiford, who had completed the original PCR. (*Id.* ¶ 57.) They had transported a patient from a third floor apartment in New Haven, Connecticut, to Gaylord Hospital. (*Id.* ¶ 71.) "For several weeks after that run date, Fabula witnessed verbal exchanges between . . . Bodiford and Pierson in which Pierson repeatedly instructed Bodiford that he needed to revise his original electronic PCR so that it could be submitted to Medicare for payment." (*Id.* ¶ 58.) Bodiford refused (*id.* ¶ 59), and then told Pierson that Fabula was responsible for the run. (*Id.* ¶ 60.)

[4] The TAC also alleges that "[r]egularly, when Fabula picked up patients in Waterbury, the nurse at the hospital simply left a signed PCR on the desk with no information filled out, and Fabula along with the ambulance personnel were instructed by management to fill this in themselves with a medically necessary reason for the run." (TAC ¶ 88.) Nothing else in the TAC suggests that nurses needed to sign PCRs, however. Thus, it seems likely that this paragraph was intended to refer to PCSs, which, according to the TAC, required a signature from a nurse or physician.

Thereafter, Pierson attempted to get Fabula to revise the PCR. (*Id.* ¶ 61.) Fabula was out on sick leave after December 25, 2011, (*id.* ¶ 62), so in February 2012, Pierson contacted Fabula by e-mail, explained that the original PCR had been lost, (*id.* ¶ 63), and ordered Fabula "to return to AMR to recreate an electronically filed PCR . . . ." (*Id.* ¶ 62.) The TAC alleges, however, that "'losing' a run form was virtually impossible" with the computerized billing system. (*Id.* ¶ 64.) Fabula responded that he was uncomfortable with the request. (*Id.* ¶ 65.) Fabula returned to work that month and Pierson told him: "[y]ou should be able to complete the PCR with the information I've provided. I have the patient information. I just need the PCR recreated for billing purposes." (*Id.* ¶ 66.) "Pierson then placed before Fabula information that was (and is) used to determine if a patient needs an ambulance, and also if the patient needs the level of care that AMR is billing Medicare for," (*id*) and told Fabula to input the following information into the electronic PCR:

> Patient with history for advanced stage multiple sclerosis and is bed confined with severe contraction of the hands, arms, hips, legs and feet. Patient going to Gaylord Hospital for bactofin trail/ Testos procedure. Patient also with decubilis ulcer on lower back. Patient had no changes en route to facility. Patient left in room with staff.

(*Id.* ¶¶ 67, 72.) In addition, the form said: "Time at Scene: 6:43.05" and "Time at [Patient's] Side: 6:44.05." (*Id.* ¶ 75.) The TAC states that "[t]hese words were not Fabula's words. He would never put 'bactofin trail/Testos procedure' into a PCR; in fact, he didn't even know what these words meant." (*Id.* ¶ 74.) In addition, "[n]o EMT is at the patient's side one minute after arrival. He needs between 5 and 10 minutes just to unload all his equipment from the ambulance," (*id.* ¶ 75) and reaching the third floor of an apartment building "would require even more time." (*Id.* ¶ 76.) Thus, the TAC states that "Fabula was being asked to falsify a document

in order to have Medicare pay." (*Id.*) Fabula did not revise the PCR as Pierson requested. (*Id.* ¶ 79.)

Fabula then received a letter from AMR dated March 1, 2012, stating: "Please contact this office immediately to arrange a time for reconciliation and transmission of this EPCR [electronic PCR]. Failure to do so will result in corrective action up to and including termination." (*Id.* ¶ 78.) Fabula refused to change the PCR (*id.* ¶ 79), and "was placed on administrative leave 'until he completed the document.' He was told by Pierson that his refusal 'was a direct violation of [the] company's standard operating procedure.'" (*Id.* ¶ 80.) Since Fabula never returned to revise the PCR, he was effectively terminated. (*Id.* ¶ 81.) As a result of Fabula's refusal to change the PCR, AMR "was not successful in submitting its claim for payment to Medicare for the transport that is supposed to have occurred on December 4, 2011." (*Id.* ¶ 83.)

On another occasion, for which the TAC does not provide a date, Fabula arrived at a hospital after receiving a request for a transport "to find a patient sitting on a stretcher saying, 'Take me home.' Fabula went to AMR's hospital liaison (a woman named Nancy) and said, 'Why does this person need an ambulance?'"[5] (*Id.* ¶ 84.) Nancy said that the patient had cancer. Fabula said, "'The patient doesn't get Medicare for this,' so Nancy put down dementia. Then when Fabula said, 'Dementia is not covered unless the patient is violent or wandering,' Nancy went back and found something in the hospital record about an incident 3 years ago. 'The patient has violent tendencies,' she said, and put down that, 'Today, the patient is violent.'" (*Id.* ¶ 85.)

On July 7, 2011, paramedic William Shick and Fabula transported several patients to the hospital based on 911 calls. (*Id.* ¶ 102.) Two weeks later, Fabula was asked to revise their PCRs.

[5] Because paragraph 54 of the TAC identifies Nancy Terenzo as a hospital liaison at an unnamed hospital, it appears that this paragraph also refers to Nancy Terenzo.

(*Id.*) "These patients were on Medicaid and Fabula was told he had to write in previous surgeries and injuries to justify their need for transport. One of them . . . wanted a ride to the hospital because she felt she could 'skip the line' if an ambulance brought her in. She was going in for a chronic allergy issue. Another was from the homeless shelter in New Haven, and called 911 because he didn't feel like he should have to buy cough syrup." (*Id.*)

AMR transported a patient to and from dialysis appointments three times per week all summer long in 2011. Although the patient could not stand and walk at first, "after a short period of time, he was able to walk and to sit up on a stretcher." (*Id.* ¶ 109.)

Fabula transported a patient for a medical appointment on October 17, 2011. The transport was canceled, however, because it was the wrong date for the medical appointment. Nevertheless, "AMR still required Fabula to complete a return trip PCR, as if the patient had been transported twice, when in fact he was only transported one time." (*Id.* ¶ 101.)

On December 4, 2011, EMT Douglass Gladstone and Fabula assisted in transporting an obese patient who, according to the TAC, "had no medical reason to be sent to the hospital, he simply wanted to go there." (*Id.* ¶ 100.) The patient "was able to walk himself to the stretcher, and climb on unassisted." (*Id.*) Nevertheless, "AMR instructed Fabula to write down [the patient's] previous surgeries to justify his transport to the hospital." (*Id.*) The TAC also alleges that the same patient "called 911 for an ambulance on a daily basis - six dozen times during 2011 - to bring him to his medical facility - for his insulin." (*Id.* ¶ 108.) For these runs, "Fabula was directed . . . to change and falsely certify . . . the PCRs in order to say that [the patient] had difficulty remaining in an upright position in order to qualify . . . [the] runs . . . for Medicare/Medicaid reimbursement. . . . [U]pon information and belief they were submitted to Medicare for payment." (*Id.*)

Ten days later, on December 14, 2011, Amy Baitch and Fabula transferred two patients between medical facilities. According to the TAC, the first "patient was alert and oriented, able to stand and pivot, and had no reason to travel by ambulance except for the fact that AMR placed the calls as '911,' rather than standard transport, and thus Medicare was billed for the transport." (*Id.* ¶ 97.) The second "patient could have traveled by other means, but the call was placed as a 911 call rather than a scheduled transport and on information and belief, Medicare was billed." (*Id.* ¶ 98.)

Two days later, on December 16, 2011, Paul Zadrozny, then an AMR dispatcher, offered Fabula a run transporting a patient from New Haven to Guilford, Connecticut. Zadrozny told Fabula that Fabula "would be required to fill in the paperwork properly to ensure Medicare would pay the bill. AMR wanted Fabula to write 'patient is unable to sit at a 90 degree angle due to hip fracture.' However, the hip fracture . . . was over 5 years earlier, and the patient had already fully recovered." (*Id.* ¶ 96.)

The TAC makes several other allegations regarding specific AMR employees, but the allegations themselves are general, and do not refer to specific transports or fraudulent activities:

- Oliver Tatum, a paramedic, told Fabula that "[h]e was very uncomfortable with AMR 'putting their words on our paperwork.'" (*Id.* ¶ 94.)
- EMT Ronald Deline got in trouble on December 25, 2011, "for submitting paperwork that was not reimbursable by Medicare." Deline "was angry that AMR was 'trying to tell him the condition of his patients.'" (*Id.* ¶ 95.)
- EMT Rich Acampora "complained to Fabula in 2011 how it had gotten really bad, saying, 'They want you to write what they want on the form every time . . .'" (*Id.* ¶ 103.)
- EMT Rob Phelan, apparently angry and overwhelmed by all the paperwork he had been ordered to redo, told Fabula that he would "make them pay." Phelan then arranged to complete the paperwork after hours so that AMR would have to pay him overtime for doing so. (*Id.* ¶ 104.)

3. Corporate Integrity Agreement

In May of 2011, AMR entered into a Corporate Integrity Agreement ("CIA") with the Office of the Inspector General of the Department of Health and Human Services. (*Id.* ¶ 118.) As part of the CIA, AMR promised to comply with Medicare's statutes, regulations, and written directives. (*Id.*) The TAC alleges, however, that "AMR used this CIA to shield its continuing practice of defrauding the government and maximizing its reimbursement of funds to which it was not entitled." (*Id.* ¶ 126.) "In early summer of 2011 . . . all AMR ambulance personnel were required to attend companywide sessions for training to address AMR's 'new documentation policies.'" (*Id.* ¶ 127.) Boyd told ambulance employees that New Haven received reimbursement from Medicare for 40% of its runs, while other AMR locations were reimbursed for closer to 70% of their runs. (*Id.* ¶ 131.) The TAC alleges, on information and belief, that AMR's goal after signing the CIA was to increase New Haven's reimbursements from Medicare to 70% of its runs. (*Id.* ¶ 132.)

Boyd also told New Haven ambulance employees that "[p]oor documentation leads to calls not being paid for," (*id.* ¶ 133), and that a new software program would help "guide" employees to prepare "better" PCRs. (*Id.* ¶ 134.) "Ambulance personnel understood 'better' to mean getting more of the ambulance runs to qualify for Medicare reimbursement." (*Id.* ¶¶ 134, 136.) Boyd told AMR ambulance personnel that Medicare would pay "only when key words and descriptions" are in the electronic PCRs. (*Id.* ¶¶ 135, 136.) Once clicked or checked, the fields in the new software program auto-filled "the requirements necessary to get Medicare to pay." (*Id.* ¶ 138.) The new software program apparently required that the box for "paramedic assessment" or Advance Life Support ("ALS") assessment be checked in order for a PCR to be processed. (*Id.* ¶ 142.) Such assessments involved "advanced medical monitoring or care with heart monitoring,

medications, [or] advanced airways." (*id.* ¶ 144), and were billed to Medicare at $1,200 each. (*Id.* ¶ 143.) AMR's new software automatically checked "paramedic assessment" if a paramedic was present in the ambulance, even if such an assessment was not necessary and was not performed. (*Id.* ¶¶ 146, 147.) "The result was that Medicare automatically was billed . . . $1,200." (*Id.* ¶ 147.) The TAC also alleges that the new software would automatically describe every patient as "bed confined," regardless of the patient's actual condition. (*Id.* ¶ 148.) AMR "programm[ed] its software to bill at the highest level of care possible in order to qualify for Medicare reimbursement." (*Id.* ¶ 140.)

Despite these automations in the new software, the number of PCRs that each EMT was asked to correct or redo increased from several to about 30 per shift. (*Id.* ¶¶ 150-153.) In 2011, someone asked Boyd "if the new (but illegal and fraudulent) way of completing the PCRs 'was working' – whether the effort to increase Medicare billings (no matter by what means) 'was working,'" and "Fabula heard Boyd respond, 'Hey, it's working.'" (*Id.* ¶ 163.)

II. LEGAL STANDARDS

A. Rule 12(b)(6)

Under Fed. R. Civ. P. 12(b)(6), the Court must determine whether the plaintiff has alleged "enough facts to state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570. Under *Twombly*, the Court accepts as true all of the complaint's factual allegations when evaluating a motion to dismiss. *Id.* at 572. The Court must "draw all reasonable inferences in favor of the non-moving party." *Vietnam Ass'n for Victims of Agent Orange v. Dow Chem. Co.*, 517 F.3d 104, 115 (2d Cir. 2008). For a complaint to survive a motion to dismiss, "[a]fter the court strips away conclusory allegations, there must remain sufficient well-pleaded factual allegations to nudge plaintiff's claims across the line from

conceivable to plausible." *In re Fosamax Products Liab. Litig.*, 2010 WL 1654156, at *1 (S.D.N.Y. Apr. 9, 2010).

B. The FCA and the Rule 9(b) Requirement of Particularity

Under the FCA, private individuals, known as "relators," may file *qui tam* actions and recover damages on behalf of the United States from any person who "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval," 31 U.S.C. 3729(a)(1)(A), or who "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." 31 U.S.C. § 3729(a)(1)(B). "Claim" means "any request or demand . . . for money or property" that: "(i) is presented to an officer, employee, or agent of the United States," or "(ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government . . . provides or has provided any portion of the money or property requested or demanded." 31 U.S.C. § 3729(b)(2)(A). "The submission of a false claim to the government is the cornerstone of any fraud claim pursuant to the FCA," *Johnson v. The Univ. of Rochester Med. Ctr.*, 686 F. Supp. 2d 259, 266 (W.D.N.Y. 2010), and such a submission "is an essential element of causes of action under subsections (a)(1)(A) and (a)(1)(B)." *U.S. ex rel. Kester v. Novartis Pharm. Corp.*, 23 F. Supp. 3d 242, 253 (S.D.N.Y. 2014) ("*Novartis II*"); *see also, U.S. ex rel. Karvelas v. Melrose-Wakefield Hosp.*, 360 F.3d 220, 243 (1st Cir. 2004) (The FCA "attaches liability to the submission of false claims for payment, not to the underlying fraudulent activity or other wrongful conduct on which those claims were based.") *abrogation on other grounds recognized by U.S. ex rel. Gagne v. City of Worcester*, 565 F.3d 40, 46 (1st Cir. 2009); *U.S. ex rel. Clausen*

v. Lab. Corp. of Am., 290 F.3d 1301, 1311 (11th Cir. 2002) ("The submission of a claim is . . . the *sine qua non* of a False Claims Act violation.").

"[C]laims brought under the FCA fall within the express scope of Rule 9(b)" of the Federal Rules of Civil Procedure, *Gold v. Morrison-Knudsen Co.*, 68 F.3d 1475, 1477 (2d Cir. 1995), which requires that a party "alleging fraud or mistake . . . state with particularity the circumstances constituting fraud or mistake." Fed.R.Civ.P. 9(b). "To satisfy this requirement the plaintiff 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." *Anschutz Corp. v. Merrill Lynch & Co.*, 690 F.3d 98, 108 (2d Cir. 2012) (internal citation and quotation marks omitted). "In other words, Rule 9(b) requires that a plaintiff set forth the who, what, when, where and how of the alleged fraud." *U.S. ex rel. Polansky v. Pfizer, Inc.*, No. 04-CV-0704 (ERK), 2009 WL 1456582, at *4 (E.D.N.Y. May 22, 2009) (internal citation and quotation mark omitted).

The heightened pleading standard under Rule 9(b) has several purposes: "to provide a defendant with fair notice of a plaintiff's claim, to safeguard a defendant's reputation from improvident charges of wrongdoing, and to protect a defendant against the institution of a strike suit." *O'Brien v. Nat'l Prop. Analysts Partners*, 936 F.2d 674, 676 (2d Cir. 1991) (internal citation and quotation marks omitted). Another purpose of Rule 9(b) "is to discourage the filing of complaints as a pretext for discovery of unknown wrongs." *Madonna v. United States*, 878 F.2d 62, 66 (2d Cir. 1989) (internal citation and quotation marks omitted). That purpose is an apt one for FCA claims, which are brought by private parties for wrongs done to another, *i.e.,* the United States government. "The reluctance of courts to permit qui tam relators to use discovery to meet the requirements of Rule 9(b) reflects, in part, a concern that a qui tam plaintiff, who has

suffered no injury in fact, may be particularly likely to file suit as a pretext to uncover unknown wrongs." *Karvelas*, 360 F.3d at 231 (internal quotation marks and citation omitted).

"Although the Second Circuit has not explained exactly what Rule 9(b) demands of FCA claims, the weight of authority from district courts within this Circuit is that where an alleged FCA violation involves the submission of a false claim to the Government for reimbursement, the details of that false claim must be pled with particularity." *U.S. ex rel. Moore v. GlaxoSmithKline, LLC*, No. 06 CIV. 6047 BMC, 2013 WL 6085125, at *3 (E.D.N.Y. Oct. 18, 2013) (internal citation and quotation marks omitted) (collecting cases); *see U.S. ex rel. Kester v. Novartis Pharm. Corp.*, No. 11 CIV. 8196 CM, 2014 WL 2619014, at *5 (S.D.N.Y. June 10, 2014); *Novartis II* at 257 (collecting cases); *U.S. ex rel. Mooney v. Americare, Inc.*, No. 06-CV-1806 FB VVP, 2013 WL 1346022, at *3 (E.D.N.Y. Apr. 3, 2013); *Johnson*, 686 F. Supp. 2d at 267 (collecting cases); *Wood ex rel. U.S. v. Applied Research Associates, Inc.*, 328 F. App'x 744, 750 (2d Cir. 2009) (summary order) (quoting, with approval, the district court's statement that the complaint "do[es] not cite to a single identifiable record or billing submission they claim to be false, or give a single example of when a purportedly false claim was presented for payment by a particular defendant at a specific time."); *U.S. ex rel. Smith v. Yale Univ.*, 415 F. Supp. 2d 58, 86-87 (D. Conn. 2006). Thus, an FCA complaint must include "details that identify particular false claims for payment that were submitted to the government," such as:

> details concerning the dates of the claims, the content of the forms or bills submitted, their identification numbers, the amount of money charged to the government, the particular goods or services for which the government was billed, the individuals involved in the billing, and the length of time between the alleged fraudulent practices and the submission of claims based on those practices. . . . These details do not constitute a checklist of mandatory requirements that must be satisfied by each allegation included in a complaint. However, . . . we believe that some of this information for at least some of the claims must be pleaded in order to satisfy Rule 9(b).

Karvelas, 360 F.3d at 233 (internal quotation marks and citations omitted).

> In sum, a plaintiff asserting a claim under subsection (a)(1)(A) or (a)(1)(B) must plead the submission of false claims with a high enough degree of particularity that defendants can reasonably identify particular false claims for payment that were submitted to the government. The details included in the complaint must fulfill the purposes of Rule 9(b) by both (1) identifying which of the claims the defendant submitted were "false," and (2) providing a factual basis to support the plaintiff's assertion that claims were actually submitted to a government program.

Novartis II, 23 F. Supp. 3d at 260 (internal quotation marks and citations omitted).

III. DISCUSSION

Chorches argues that, "the TAC sufficiently alleges numerous false claims by AMR." (Plaintiff's Opposition Brief, ("Pl.'s Opp. Br."), ECF No. 80 at 1.) He argues that the "who" in the TAC is AMR, the "what" is "the submission of claims for payment for ambulance transports that were misrepresented as being 'medically necessary,'" (Pl.'s Opp. Br. at 6), the "where" is the submission of false claims to Medicare and Medicaid, the "when" is "the occurrence dates of transports misrepresented as medically necessary," (*id.* at 8), and the "how" is AMR's directing its personnel "to alter or create PCRs indicating that medically unnecessary transports[] were medically necessary, so that the transports could be billed to Medicare or Medicaid." (*Id.* at 9.) Chorches contends that by "identifying particular people . . . for whom ambulance transports were misrepresented as medically necessary, the TAC undeniably identifies the 'what' of certain false claims with precision." (*Id.* at 6.) While the TAC does describe multiple ambulance transports, and often identifies the patients, the locations to and from which the patients were transported, and the dates of the transports, it does not provide details about any false claims that were actually submitted to the federal government for reimbursement.[6]

[6] Thus, as AMR points out, Chorches's reliance on *In re Cardiac Devices Qui Tam Litig.*, 221 F.R.D. 318 (D. Conn. 2004) is misplaced. In that case, the government "described in detail the alleged violations of the FCA and . . . provided categorical information in the complaints about the actual claims that were

For many of the transports it describes, the TAC does not allege that AMR ever submitted false claims to the federal government for reimbursement. For example, on one occasion, Fabula was assigned to transport a patient, and when he asked AMR's hospital liaison why the patient needed an ambulance, she told him that the patient had cancer. (TAC ¶¶ 84-85.) When Fabula explained that Medicare would not cover the transport, the liaison "put down dementia." (*Id.* ¶ 85.) When Fabula explained that dementia is not covered unless the patient is violent or wandering, the liaison "went back and found something in the hospital record about an incident 3 years ago. 'The patient has violent tendencies,' she said, and put down that, 'Today, the patient is violent.'" (*Id.*) The TAC does not allege that a claim related to this transport was ever submitted to Medicare or Medicaid. The allegations about this transport also fall short of the Rule 9(b) standard for other reasons, including that no date is provided, the hospital is not identified, and the document in which the hospital liaison allegedly wrote "Today, the patient is violent" is not specified.

Similarly, there are no allegations that AMR ever submitted any false claims to the federal government for reimbursement for the following transports described in the TAC:

- On July 7, 2011, Shick and Fabula transported several patients to the hospital based on 911 calls. (*Id.* ¶ 102.) "One of them . . . wanted a ride to the hospital because she felt she could 'skip the line' if an ambulance brought her in. She was going in for a chronic allergy issue. Another was from the homeless shelter in New Haven, and called 911 because he didn't feel like he should have to buy cough syrup." (*Id.*) Two

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submitted to the Government, listing the number of false claims involving a particular device." *Cardiac Devices*, 221 F.R.D. at 336. The government provided spreadsheets to the defendants, some of which "included the specific amount of the Medicare or Medicaid reimbursement for the specific procedure." *Id.* Thus, the *Cardiac Devices* court found that "the complaints . . . read in conjunction with the patient lists provided to the hospitals . . . sufficiently identified the submission of specific false claims. This is not a situation where only a general scheme of fraud was alleged that might have resulted in the submission of false claims." *Id.* By contrast, the TAC alleges, in some detail, a scheme of fraud, *i.e.* falsely completing PCRs, but it does not identify or describe with particularity any specific false claims that were actually submitted to the federal government for payment.

weeks later, Fabula was asked to revise their PCRs. "Fabula was told he had to write in previous surgeries and injuries to justify their need for transport." (*Id.*)

- AMR transported a patient to and from dialysis appointments three times per week all summer long in 2011. Although the patient could not stand and walk at first, "after a short period of time, he was able to walk and to sit up on a stretcher." (*Id.* ¶ 109.)[7]

- Fabula transported a patient for a medical appointment on October 17, 2011. The transport was canceled, however, because it was the wrong date for the appointment. Nevertheless, "AMR still required Fabula to complete a return trip PCR, as if the patient had been transported twice, when in fact he was only transported one time." (*Id.* ¶ 101.)[8]

- On December 16, 2011, Zadrozny offered Fabula a run transporting a patient from New Haven to Guilford, Connecticut. Although the patient had a hip fracture and replacement five years earlier, and had fully recovered, Zadrozny told Fabula that "AMR wanted Fabula to write 'patient is unable to sit at a 90 degree angle due to hip fracture.'" (*Id.* ¶ 96.)[9]

Moreover, "some of the [allegations] tend[] to show that fraudulent bills were *not* submitted." *Smith*, 415 F. Supp. 2d at 88. For example, after a run on December 4, 2011, "Pierson repeatedly instructed Bodiford that he needed to revise his original electronic PCR so that it could be submitted to Medicare for payment." (TAC ¶ 58.) After Bodiford refused, Pierson told Fabula, "[y]ou should be able to complete the PCR with the information I've provided. I have the patient information. I just need the PCR recreated for billing purposes." (*Id.* ¶ 66.) The TAC alleges that as a result of Bodiford's and Fabula's refusals to change the PCR, AMR "was *not* successful in submitting its claim for payment to Medicare for the transport that is supposed to have occurred on December 4, 2011." (*Id.* ¶ 83 (emphasis added).) Thus, the TAC

[7] With respect to this transport, there is also no allegation that false entries about the patient were made in a PCR or other documents.

[8] With respect to this transport, there is also no allegation that the patient was eligible for Medicare or Medicaid.

[9] With respect to this transport, there is also no allegation that the patient was eligible for Medicare or Medicaid or that a false entry was actually made in a PCR or other document.

affirmatively states that this claim was never actually submitted to the federal government for payment.

In other cases, the TAC tacks on to the end of a description of a specific transport the conclusory allegation—often pled on "information and belief"—that the transport services provided were "billed to Medicare." For example, the TAC includes the following allegations:

- An obese patient "called 911 for an ambulance on a daily basis - six dozen times during 2011 - to bring him to his medical facility - for his insulin." (TAC ¶ 108.) For these runs, "Fabula was directed . . . to change and falsely certify . . . the PCRs in order to say that [the patient] had difficulty remaining in an upright position in order to qualify . . . [the] runs . . . for Medicare/Medicaid reimbursement. . . . [U]pon information and belief they were submitted to Medicare for payment." (*Id.*)
- On December 14, 2011, Baitch and Fabula transferred two patients between medical facilities. The first "patient was alert and oriented, able to stand and pivot, and had no reason to travel by ambulance . . . ." (*Id.* ¶ 97.) The second "patient could have traveled by other means, but the call was placed as a 911 call rather than a scheduled transport and on information and belief, Medicare was billed." (*Id.* ¶ 98.)
- Fabula called dispatcher Tom DellaValle to determine why a particular patient needed an ambulance. "DellaValle, being a dispatcher who had access to the patient's records, said, 'Well, she had a hip fracture three years ago.' So Fabula wrote on the PCR form, 'Hip fracture,' as though it had just occurred, and, on information and belief, the run was processed for Medicare reimbursement." (*Id.* ¶ 105.) [10]

Such conclusory allegations as to the core FCA element that a false request for payment was submitted to the government do not satisfy the particularity requirement of Rule 9(b).

Chorches ultimately recognizes that he cannot plead the submission of actual false claims to the government with particularity, and seeks to be excused from this requirement on the ground that billing information is in the custody and control of AMR:

> While AMR required that its EMTs and Paramedics personally certify whether ambulance runs were medically necessary – whether they were actually medically

[10] The TAC also alleges, generally, that AMR's new software automatically checked "paramedic assessment" if a paramedic was present in the ambulance, even if such an assessment was not necessary and was not performed. (*Id.* ¶¶ 146, 147.) "The result was that Medicare automatically was billed . . . $1,200." (*Id.* ¶ 147.)

> necessary or not – AMR did not invite or require either Fabula or any of its other ambulance personnel to participate in the billing procedures. . . . [T]hey were not involved in billing Medicare or Medicaid for their ambulance runs. This was a task delegated to those in the billing department at AMR. As a result, specific information about AMR's submissions to Medicare – in the fraudulent PCRs by AMR emergency personnel – is information particularly within the knowledge and control of, and access to, the defendant, AMR, and not accessible by any paramedics or EMTs such as Fabula.

(*Id.* ¶ 115.) In making this allegation, Chorches seeks to invoke the more "relaxed" pleading standard applicable—even for allegations subject to Rule 9(b)—when the relevant facts are not accessible to the pleader. More specifically, "[d]espite 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." *Wexner v. First Manhattan Co.*, 902 F.2d 169, 172 (2d Cir. 1990) (citations omitted). Such a "relaxed pleading standard," however, "must not be mistaken for license to base claims of fraud on speculation and conclusory allegations . . . . [A] complaint must adduce specific facts supporting a strong inference of fraud . . . ." *Id.* (internal citations omitted). A plaintiff who pleads based on information and belief "must still set forth the factual basis for that belief, and that basis must arise from the plaintiff's direct, independent, firsthand knowledge."[11] *Johnson*, 686 F. Supp. 2d at 266.

The TAC does not satisfy this "relaxed" standard because it does not plead the factual basis for the relator's belief that "Medicare was billed." This is not merely a technical omission. There are allegations in the TAC that suggest that many of the transports provided by AMR were not billed to the government at all. The TAC pleads that before AMR signed the CIA in May

[11] Courts have also relaxed the pleading requirements of Rule 9(b) in cases "involv[ing] complex or extensive schemes of fraud." *Cardiac Devices*, 221 F.R.D. at 333. "[W]here the alleged fraudulent scheme involved 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," instead allowing the relator to describe specific examples of false claims. *Id.* Here, as noted, the TAC does not provide a single specific "example" of a false claim submitted to the government.

2011, "a relatively low percentage of [AMR's] ambulance runs" out of the New Haven office where Fabula worked were "being billed to Medicare." (TAC ¶ 130.) The TAC suggests that this percentage was approximately 40% before the CIA was signed, and that after it was signed, AMR sought to raise that percentage to 70%. (*Id.* ¶ 131.) The TAC thus suggests that only 40% to 70% of AMR's transports were being billed to the government—the remainder presumably being billed either to private payors or to no one at all. Especially because the TAC itself suggests that the odds were roughly fifty percent that any given transport was *not* billed to the government, the failure to allege with specificity the basis for the relator's belief that a particular transport was billed to the government, as opposed to a private payor or to no one at all, is a fatal omission.

Chorches argues that allegations in the TAC regarding the purpose of the scheme to revise the PCRs provide an indication of the basis for his belief that specific transports were being billed to the government. For example, the TAC alleges that:

- "Fabula was informed by Boyd, Pierson, and Martus, that the revisions were required to qualify the run for Medicare reimbursement." (*Id.* ¶ 33) AMR supervisors gave EMTs "notes providing instructions as to how the PCRs should be modified and changed with false information – which then was inputted electronically . . . – in order to qualify the runs for Medicare reimbursement" (*Id.* ¶ 38);
- "AMR supervisors routinely, on a daily basis . . . informed the EMTs, when they were being ordered to change the PCR forms, that 'Medicare is not paying for the dementia patient the way you have it written.'" (*Id.* ¶ 39.) Under threat of adverse employment action, EMTs "were routinely required to change the histories with Alzheimer's patients – so that the history included in the PCR a component of 'violence' – in order to qualify for Medicare." (*Id.*);
- Even "when medical treatment was not required, AMR nonetheless required its employees, under threat of discontinuing their employment, to change the PCRs to qualify for Medicare reimbursement." (*Id.* ¶ 47);
- "Fabula witnessed verbal exchanges between . . . Bodiford and Pierson in which Pierson repeatedly instructed Bodiford that he needed to revise his original electronic PCR so that it could be submitted to Medicare for payment." (*Id.* ¶ 58.) After Bodiford refused, Pierson asked Fabula to enter certain information into the PCR "in

order to ensure that AMR could bill Medicare for the transport." (*Id.* ¶ 71.) Pierson said, "[y]ou should be able to complete the PCR with the information I've provided. I have the patient information. I just need the PCR recreated for billing purposes." (*Id.* ¶ 66.) The TAC states that, "Fabula was being asked to falsify a document in order to have Medicare pay." (*Id.* ¶ 76);

- For an obese patient, "Fabula was directed . . . to change and falsely certify . . . the PCRs in order to say that [the patient] had difficulty remaining in an upright position in order to qualify . . . [the] runs . . . for Medicare/Medicaid reimbursement. . . ." (*Id.* ¶ 108); and
- AMR "program[ed] its software to bill at the highest level of care possible in order to qualify for Medicare reimbursement." (*Id.* ¶ 140.)

But these allegations add little to the mix and fall short of satisfying Chorches's burden under Rule 9(b). First, with the exception of the PCR for the December 4, 2011 run that was never actually submitted to Medicare (described in the fourth bullet point above), there are no specific allegations—that is, no specification of a date or speaker—that anyone told Fabula that the purpose of requiring him to revise a PCR with respect to a particular transport was so that it could be billed to Medicare. And the TAC otherwise offers no facts suggesting that Fabula would have personal knowledge of the intent behind the instructions he was allegedly receiving. Second, alleging the purpose of the scheme to revise the PCRs ultimately amounts to little more than saying that the scheme was fraudulent, and it is well-established that it is not enough to plead that the underlying scheme was fraudulent in a FCA case; there must, in addition, be particularized allegations that a false claim was actually submitted to the government for payment. *Polansky*, 2009 WL 1456582, at *5 ("[A] relator cannot circumscribe the Rule 9(b) pleading requirements by alleging a fraudulent scheme in detail and concluding, that as a result of the fraudulent scheme, false claims must have been submitted.") (citing First, Third, Tenth, and Eleventh Circuit cases); *Johnson*, 686 F. Supp. 2d at 266 (noting that the "complaint offers nothing more than conclusory allegations and assumptions that the pattern of incidents the plaintiffs describe ever actually resulted in a fraudulent bill being submitted to Medicare and/or

Medicaid for payment."); *id.* at 268 ("Neither plaintiff has identified any particular case where a fraudulent bill was presented, nor have they provided any factual basis upon which to conclude that they personally observed or had reason to know that fraudulent claims were submitted. As such, their fraud claims must be dismissed."); *Novartis II* at 255 (under *Karvelas,* "both the fraudulent scheme and the submission of false claims must be pled with a high degree of particularity."); *U.S. ex rel. Smith,* 415 F. Supp. 2d at 87 (dismissing plaintiff's claims under "relaxed" standard for failure to plead fraud with particularity—despite relator's detailed description of the defendant's non-compliance with regulations—because relator merely provided conclusory allegations that the defendant "must have submitted claims for reimbursement from the Medicare program . . . for all such signed reports for Medicare patients"). Again, "actual false and fraudulent claims are the *sine qua non* of a False Claims Act litigation." *Polansky,* 2009 WL 1456582, at *5 (internal quotation marks and citations omitted). Here, the failure to plead facts showing that specific transports were actually billed to the government—especially when the TAC suggests approximately half were not—is a fatal omission.

Because the TAC does not provide a factual basis for its conclusory allegations that AMR submitted false claims to Medicare or Medicaid for reimbursement, it fails to satisfy Rule 9(b), even under the "relaxed" pleading standard. Therefore, the TAC is dismissed with prejudice.

IV. CONCLUSION

For the reasons stated above, AMR's motion to dismiss (ECF No. 77) is GRANTED, and the Clerk is instructed to close this case.

One final matter: AMR argues that Chorches violated the Health Insurance Portability and Accountability Act ("HIPAA") by improperly disclosing patient names and medical

information in the TAC. Chorches is ordered to show cause, by November 20, 2015, why the TAC should not be sealed to protect the confidentiality of the patients named, and a new, redacted TAC filed replacing each patient's name with an anonymous identifier such as "Patient A, Patient B," etc.

IT IS SO ORDERED.

/s/
Michael P. Shea, U.S.D.J.

Dated: Hartford, Connecticut
November 6, 2015

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

PAUL FABULA
USA
Plaintiffs

vs. CASE NO. 3:12cv921 (MPS)

AMERICAN MEDICAL RESPONSE, INC.
Defendant

RONALD I. CHORCHES, Trustee for the Bankruptcy Estate
Trustee

JUDGMENT

This action having come on for consideration of the defendant's Motion to Dismiss before the Honorable Michael P. Shea, United States District Judge, and

The Court having considered the motion and the full record of the case including applicable principles of law, and having filed its ruling on November 6, 2015 granting the motion, it is therefore

ORDERED, ADJUDGED and DECREED that the judgment be and is hereby entered in favor of the defendant dismissing the case.

Dated at Hartford, Connecticut, this 10th day of November, 2015.

ROBIN D. TABORA, Clerk

By /s/ DJ
Devorah Johnson
Deputy Clerk

EOD 11/10/15

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

UNITED STATES OF AMERICA ex rel. RONALD I. CHORCHES, Bankruptcy Trustee, Bringing this action on behalf of THE UNITED STATES OF AMERICA and the ESTATE OF PAUL FABULA, and PAUL FABULA, Individually Plaintiff-Relator/Plaintiff, vs. AMERICAN MEDICAL RESPONSE, INC., Defendant.	Civil Action No. 3:12-CV-921 (MPS)

NOTICE OF APPEAL

Notice is hereby given, pursuant to Fed. R. App. P. 3(a), that relator Ronald I. Chorches, Bankruptcy Trustee, and plaintiff Paul Fabula, individually, hereby appeal to the United States Court of Appeals for the Second Circuit from this Court's Memorandum and Order (Doc. 82), entered in this action on November 6, 2015, dismissing relator's claims against defendant American Medical Response, Inc., and from this Court's Memorandum and Order (Doc. 67), entered in this action on March 4, 2015, dismissing with prejudice plaintiff's individual claims against defendant American Medical Response, Inc. in Count Two of his Second Amended Complaint, and the Court's Judgment, entered in this action on November 10, 2015 (Doc. 83) dismissing this action.

Dated: December 4, 2015

Respectfully submitted

RELATOR RONALD I. CHORCHES, in his capacity as BANKRUPTCY TRUSTEE, and PLAINTIFF PAUL FABULA, individually

By their attorneys,

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CERTIFICATE OF SERVICE

I hereby certify that on December 4, 2015, a copy of the foregoing Notice of Appeal was served via ECF on all counsel of record.

/s/ Anthony R. Zelle
Anthony R. Zelle

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

UNITED STATES OF AMERICA ex rel. PAUL FABULA	)	No. 3:12CV921 (MPS)
Plaintiff,	)	
v.	)	
AMERICAN MEDICAL RESPONSE, INC.	)	
Defendant.	)	December 8, 2015

STATEMENT OF INTEREST OF THE UNITED STATES

As the real party in interest in all *qui tam* suits, *United States ex rel. Eisenstein v. City of New York*, 540 F.3d 94 (2d Cir. 2008), the United States submits this Statement of Interest pursuant to 28 U.S.C. 517 to respectfully request that the Court issue a revised Order which clarifies that the False Claims Act allegations in this matter are dismissed without prejudice to the United States.

I. BACKGROUND

On June 22, 2012, Mr. Paul Fabula filed this *qui tam* action under seal on behalf of the United States, alleging that defendant American Medical Response (AMR) violated the False Claims Act (FCA) 31 U.S.C. 3729-3733 by submitting false claims to Medicare and Medicaid for patient transports and related services that were not medically necessary and therefore did not qualify for reimbursement. Mr. Fabula filed a First Amended Complaint on January 28, 2013 making similar allegations.

After investigating Relator's allegations, the United States gave notice that it was declining to intervene on September 27, 2013, pursuant to 31 U.S.C. § 3730(b)(4)(B). Dkt. No.

18. On November 7, 2013, the United States filed an amended notice of declination including a request that both the complaint and the first amended complaint be unsealed. Dkt. No. 22. The Court ordered the complaints unsealed on November 7, 2013. Dkt. No. 24.

Thereafter, on March 5, 2014, Mr. Fabula filed a second amended complaint, Dkt. No. 39, Count One of which similarly alleged that AMR violated the FCA by submitting claims to Medicare and Medicaid for medically unnecessary transports and related services. The Court dismissed count one of the second amended complaint on March 5, 2014, holding that Mr. Fabula lacked standing to pursue his FCA claims because they belonged to his bankruptcy estate, Dkt. No. 40-1. However, the Court stayed this portion of its ruling for thirty (30) days to allow the bankruptcy trustee to appear and prosecute Mr, Fabula's claims. Dkt. No. 67.

On April 2, 2015, the Court held a telephonic status conference call with the parties and the United States, at which time counsel for the United States requested that any dismissal of the FCA allegations in this matter be without prejudice to the United States. Following this conference, the Court ordered that the plaintiff would have one final opportunity to amend the complaint.

On April 24, 2015, the bankruptcy trustee for Mr. Fabula's estate, Mr. Ronald Chorches, filed a third amended complaint (TAC), Dkt. No. 76, which repleaded Count One—the alleged making of false statements and false claims in violation of the FCA. On May 11, 2015, AMR moved to dismiss Count One of the TAC pursuant to F.R.C.P. 9(b) and 12(b)(6), with prejudice to relator but without prejudice to the United States. Dkt. No. 77-1 at pg. 2. On November 6, 2015, this Court granted AMR's motion, dismissing the TAC with prejudice. Dkt. No. 82.

II. Dismissal Of False Claims Act Claims Should Be Without Prejudice To The United States

Consistent with its request during the April 2, 2015 Status Conference and with Defendant AMR's motion to dismiss the TAC, the United States respectfully requests that the Court issue a revised Order which clarifies that the False Claims Act allegations in this matter are dismissed without prejudice to the United States.

Pursuant to the False Claims Act, a relator files his or her complaint on behalf of the United States and, once the United States has notified the Court that it declines to pursue relator's allegations, the relator is free to pursue them on his or her own. 31 U.S.C. § 3730. Under such circumstances, the United States neither files the complaint that initiated the action nor serves it on defendants. Because the United States has no part in preparing such a complaint, it should not be prejudiced if a relator has failed to plead his or her allegations sufficiently. Accordingly, where a court grants a defendant's motion to dismiss claims in a *qui tam* action in which, as in this case, the United States not intervened, such dismissals are routinely without prejudice to the United States. *See, e.g.*, *United States ex rel. Williams v. Bell Helicopter Textron, Inc.*, 417 F.3d 450, 454-56 (5th Cir. 2005) ("[D]ismissal with prejudice as to the United States was unwarranted where, as here, the relator's claims were dismissed on a Rule 12(b)(6) motion based on a lack of specificity in the complaint as required by Rule 9(b)."); *United States ex rel. Newsham v. Lockheed Missiles & Space Co.*, 190 F.3d 963, 967 (9th Cir. 1999) (dismissal of relator's complaint on defendant's motion to dismiss was with prejudice to relator and without prejudice to the United States); *United States ex rel. Pilon v. Martin Marietta Corp.*, 60 F.3d 995, 1000 n.6 (2d Cir. 1995) (affirming dismissal of relator's complaint for failure to comply with the FCA's requirement that *qui tam* complaints be filed under seal but noting that the government could proceed with the claims against the defendants if it so chose). The preclusive

effect of a dismissal with prejudice to the United States would be of particular concern where, as here, there has been no adjudication of the merits of the issues.

III. CONCLUSION

For the foregoing reasons, the United States respectfully requests that the Court issue a revised Order which clarifies that the False Claims Act allegations in this matter are dismissed without prejudice to the United States, in order to avoid harming the United States' continuing interests in this matter.

Respectfully submitted,

DEIRDRE M. DALY
UNITED STATES ATTORNEY

By: /s/

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CERTIFICATION OF SERVICE

I hereby certify that this document, filed through the ECF system, will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF) and that paper copies will be sent to those indicated as non-registered participants on this date.

Dated: December 8, 2015

/s/
Anne F. Thidemann
Assistant United States Attorney

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

UNITED STATES OF AMERICA ex rel. RONALD I. CHORCHES, Bankruptcy Trustee,	:	
Bringing this action on behalf of the THE UNITED STATES OF AMERICA, the ESTATE OF PAUL FABULA, and PAUL FABULA, individually	:	Civ. No. 3:12-cv-921 (MPS)
Plaintiff-Relator,	:	
V.	:	
AMERICAN MEDICAL RESPONSE, INC.	:	
Defendant.	:	DECEMBER 15, 2015

NOTICE OF ELECTRONIC FILING OF
INDEX IN LIEU OF RECORD ON APPEAL/CROSS APPEAL

Plaintiff-Relator, Ronald I. Chorches, Bankruptcy Trustee, bringing this action on behalf of the United States of America, the Estate of Paul Fabula, and Paul Fabula individually, through counsel, pursuant to Rules 10 and 11 of the Federal Rules of Appellate Procedure and Rules 11 and 11.1 of the Local Rules of the United States Court of Appeals for the Second Circuit, hereby designates the following docket entries for inclusion in the Record on Appeal in this matter:

Docket Entry	Item / Date Filed
1	Complaint (with all attachments) (Entered 06/25 2012)
10	Amended Complaint (Entered 01/28/2013)
18	Government's Notice of Election to Decline Intervention (with all attachments) (Entered 09/27/2013)
22	Amended Notice of Election to Decline Intervention (Entered 11/06/2013)

39	Amended Complaint (Entered 03/05/2014)
40	Motion to Dismiss (with all attachments) (Entered 04/02/2014)
41	Notice re: Motion to Dismiss (Request for Judicial Notice) (with all attachments) (Entered 04/02/2014)
53	Memorandum in Opposition to Motion to Dismiss (with all attachments) (Entered 05/23/2014)
59	Reply to Response to Motion to Dismiss (with all attachments) (Entered 07/08/2014)
61	Notice of Additional Authority re Motion to Dismiss (with all attachments) (Entered 09/24/2014)
64	Status Report on Developments in Bankruptcy Case (with all attachments) (Entered 01/12/2015)
65	Response re: Status Report on Developments in Bankruptcy Case (with all attachments) (Entered 01/12/2015)
67	Order re: Motion to Dismiss (Entered 03/04/2015)
70	Motion for Joinder (with all attachments) (Entered 03/23/2015)
72	Memorandum in Opposition re: Motion for Joinder (Entered 03/31/2015)
73	Order re: Motion for Joinder (Entered 04/02/2015)
75	Order (Entered 04/03/2015)
76	Amended Complaint (Third) (Entered 04/24/2015)
77	Motion to Dismiss Third Amended Complaint (with attachments) (Entered 05/11/2015)
80	Reply to Response to Motion to Dismiss Answer to Amended Complaint with Affirmative Defenses (Entered 06/08/2015)
81	Reply to Response to Motion to Dismiss (Entered 06/22/2015)
82	Order granting Motion to Dismiss (Entered 11/06/2015)

83 Judgment (Entered 01/10/2015)

84 Notice of Appeal (Entered 12/04/2015)

85 Motion for Clarification (Entered 12/08/2015)

PLAINTIFF-RELATOR RONALD I. CHORCHES, BANKRUPTCY TRUSTEE, bringing this action on behalf of THE UNITED STATES OF AMERICA, the ESTATE OF PAUL FABULA, and PAUL FABULA, Individually

BY /s/ *Jonathan M. Levine*

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CERTIFICATION

I hereby certify that on December 15, 2015, the foregoing Plaintiff-Relator's Notice of Electronic Filing of Index in Lieu of Record on Appeal/Cross Appeal was filed electronically and served by mail on anyone unable to accept electronic filing. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system or by mail to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing. Parties may access this filing through the Court's CM/ECF System.

/s/ Jonathan M. Levine
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THE UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

Civil Action No. 312-CV-921 MPS

United States ex rel. RONALD I. CHORCHES
Bankruptcy Trustee,

Bringing this action on behalf of the
THE UNITED STATES OF AMERICA,
the ESTATE OF PAUL FABULA, and
PAUL FABULA, Individually
Plaintiff,

v.

AMERICAN MEDICAL RESPONSE, INC.
Defendant.

THIRD AMENDED COMPLAINT [REDACTED]

1. This is a *qui tam* action on behalf of the United States of America (pursuant to 31 U.S.C. §§ 3729 *et seq.*, and 31 U.S.C. § 3730(b)(1) of the Federal False Claims Act), and also for the benefit of the Bankruptcy Estate of Paul Fabula, and Paul Fabula, individually.

2. This action is brought to recover damages, and to impose civil penalties, in connection with defendant's practice of falsely certifying that ambulance transports performed by its business were medically necessary, so as to be reimbursable by Medicare and Medicaid (hereinafter, collectively, "Medicare"), when, in fact, they were not.

Parties

3. Ronald I. Chorches is trustee of the bankruptcy estate of Paul Fabula, and maintains a principal place of business in Wethersfield, Connecticut.

4. Paul Fabula is an individual who resides in Milford, Connecticut.

5. American Medical Response, Inc. ("AMR") is a Delaware corporation with a principal place of business in New Haven, Connecticut.

Jurisdiction and Venue

6. This is a civil action arising under the laws of the United States to redress violations of the Federal False Claims Act, and thus this Court has subject matter jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1345, and 31 U.S.C. § 3732.

7. Venue is proper in this District pursuant to 31 U.S.C. §§ 3730(b) and 3732(a), and 28 U.S.C. § 1331, because AMR's wrongful acts occurred in Connecticut.

Facts

8. AMR is the nation's largest ambulance company.

9. AMR maintains a branch office in New Haven, Connecticut, where Fabula actively worked as an Emergency Medical Technician ("EMT") from August 2010 to December 25, 2011.

10. During that 16-month period AMR also assigned Fabula to work for its separate branch offices serving Fairfield County, Greater Hartford/Northeast Connecticut, and Waterbury/Farmington Valley.

11. Fabula's work for AMR throughout that 16-month period was comprised of emergency and non-emergency medical transport services.

12. Some of the medical transportation services that Fabula provided during that period were reimbursable by Medicare.

13. More specifically, Medicare reimburses transport by ambulance if it is "medically necessary," as that term is defined in Chapter 10 of the Medicare Benefit Policy Manual.

14. Section 10.2.1, of the Medicare Benefit Policy Manual, entitled "Necessity for the Service," provides the following details of what Ambulance Services the Government will pay for, and what services it will not.

15. It provides that medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated, and that in any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services.

16. Section 10.2.2 of the Medicare Benefit Policy Manual provides further details on the standards of "Reasonableness" relating to what Ambulance Services the Government will pay for, and what services it will not, as follows.

17. "Reasonableness of the Ambulance Trip: Payment is made according to the level of medically necessary services actually furnished. That is, payment is based on the level of services furnished (provided they were medically necessary), not simply on the vehicle used. Even if a local government requires an ALS response for all calls, payment…is made only for the level of service furnished, and then only when the service is medically necessary."

18. In short, when another means of transportation could be used without endangering the individual's health – whether or not such other transportation is actually available to the individual – Medicare will not reimburse transport by ambulance.

19. As detailed below, AMR engaged in an institutionalized scheme to fraudulently obtain reimbursement from Medicare by falsely certifying that transportation of individuals by ambulance was medically necessary when it was not, and AMR submitted claims for

reimbursement that it knew were not reimbursable under the rules and regulations governing payments by Medicare.

The Manner in Which AMR Effected Its Fraudulent Schemes to Bill Medicare for Medically Unnecessary Ambulance Transports

20. AMR is obligated to respond to any 911 call that it receives for which an ambulance is requested.

21. Even if AMR believes that a call involves no medical necessity, it nevertheless must pick up the person for whom the 911 call is placed, and transport him or her to the medical facility that he or she requests.

22. Consequently, AMR is obligated to perform a significant number of ambulance transports that are not reimbursable by Medicare.

23. For every ambulance transport (*i.e.*, every "run"), including those that Fabula performed for AMR, an electronic Patient Care Report (PCR) is generated.

24. The PCRs are created electronically by emergency medical technicians ("EMTs"), like Paul Fabula, and by paramedics, during the course of, or immediately following, a run, via laptop computer.

25. Information electronically inputted in the PCR at the time of the run includes: the date, time, and address of the pickup; the name of the person being transported; and the name of the medical facility to which the person is transported.

26. The information inputted in the PCR also describes the condition of the person being transported, and thus identifies whether or not a run is "medically necessary" so as to be reimbursable by Medicare.

27. Fabula fully understood which of the ambulance runs that he performed for AMR comprised "medically necessary" transportation, and which did not, and the electronic PCRs that

he prepared in the field accurately reflected whether or not a run was reimbursable under Medicare.

28. Despite the accuracy of his field-generated PCRs, or rather because of their accuracy, Fabula frequently was required by AMR to revise or recreate his PCRs.

29. Specifically, AMR routinely provided Fabula, along with all the other EMTs and paramedics, printouts of PCRs prepared in the field.

30. Those printouts would have handwritten revisions on them which altered the substance of the original electronic PCRs so as to re-describe medically unnecessary runs, as medically necessary runs.

31. AMR ordered Fabula to revise his field-created electronic PCRs to incorporate the handwritten changes, or to create entirely new electronic PCRs that included the false information reflected the handwritten changes.

32. The printouts with the handwritten changes, and the orders to revise or recreate the originals, were received from, or at the direction of, AMR's Director of Clinical Service (Jeffrey Boyd), its Operations Supervisor (Russell Pierson), its Transportation Authorization Department Supervisor (Lindsay Martus), and their subordinates.

33. Fabula was informed by Boyd, Pierson, and Martus, that the revisions were required to qualify the run for Medicare reimbursement, and was ordered to revise or recreate the electronic PCRs under threat of suspension or termination.

34. Consequently, every day, there were piles of paper waiting for the EMTs and paramedics, before they punched out, or right after they punched in – *i.e.*, printouts of the PCRs that "needed revising."

35. Indeed, every day these printouts contained information and instructions for the EMTs and paramedics on how they were ordered to change the electronic PCRs. And every day, the EMTs and paramedics – mostly the EMTs – did what they were told. Every day they made these changes.

36. But there is no paper evidence of the changes to the PCR forms, because these printouts that Boyd, Pierson, and Martus distributed every day – the paper packets with the changes that were to be inputted electronically – did not leave the New Haven facility. Instead, they were shredded once the changes were made.

37. This entire process took place at AMR's New Haven office known as "the garage," where trucks and ambulances are kept when not in use.

38. Russ Pierson (or one of his subordinates) sat in the office by the front door of the garage where there was a walk up window where the EMTs and the paramedics punched in for the day to work on the ambulance to which they were assigned. This window, where the EMTs and the Paramedics punched in, and where they punched out after their shift was completed, was where the supervisors (Boyd, Pierson, and Martus) handed them the paperwork that needed to be "redone," with notes providing instructions as to how the PCRs should be modified and changed with false information – which then was inputted electronically by the EMTs and paramedics – in order to qualify the runs for Medicare reimbursement.

39. The various types of so-called "medical necessity" that AMR falsely certified in order to fraudulently collect reimbursement for ambulance runs from Medicare and Medicaid involved kidney dialysis patients, patients with hip replacements, patient transfers of patients with dementia, patients who previously were unable to walk but had progressed to not needing an ambulance, patients who were no longer a fall risk, and patients who could adequately

regulate their own oxygen. As for the Patient Transfers – 90% of the calls were patient transfers that took place several times a month, and many of these patients had dementia. Dementia patients accounted for the majority of rewrites that ambulance personnel were called upon to falsify. For patients with dementia who had a medical history of "violence," the transport was reimbursable by Medicare. However, very few of the dementia patients that were transported on a daily basis, week after week and month after month, were violent, and who therefore actually met Medicare's standards of the "medical necessity" for ambulance payments. The overwhelming majority of the dementia patients were calm and cooperative but simply confused, and when the patients were simply forgetful, Medicare didn't pay. An estimate of the number of patients that suffered from dementia or Alzheimer's was approximately 40%, yet very few of these dementia patients actually met Medicare's requirements for an ambulance. So, when Fabula and the other EMTs wrote in the original PCR during the transport that the patient simply was forgetful, AMR changed the history. Fabula was ordered to rewrite the PCR under the threat of repercussions. The aforementioned AMR supervisors routinely, on a daily basis in the garage, informed the EMTs, when they were being ordered to change the PCR forms, that "Medicare is not paying for the dementia patient the way you have it written." So Fabula and the other ambulance EMTs at AMR were routinely required to change the histories with Alzheimer's patients – so that the history included in the PCR a component of "violence" – in order to qualify for Medicare. And if the ambulance personnel didn't make these changes, they all risked getting suspended or terminated.

40. The illegal changes that the AMR personnel were required to falsify also involved unsteady gait and poor balance. AMR tried to rationalize that patients with an unsteady gait would be unable to travel by wheelchair van, but the majority of this type of patient that

ambulance personnel transported for this reason were in fact able to stand and pivot to the stretcher with little to no assistance. These types of patients normally had a wheelchair at home that they used around home, or around their nursing home, or that they used and traveled in when not going to medical appointments by a wheelchair van. And if they were capable of using the wheelchair van, their transport by ambulance did not qualify for Medicare.

41. The illegal changes that the AMR personnel were required to falsify also involved patients who were unable to regulate their own oxygen. This was another reason that accounted for a large number of rewrites. If a patient was unable to properly regulate their own oxygen due to a mental disability or a physical handicap, they qualified for transport by ambulance that was Medicare reimbursable. Yet when Fabula and other AMR ambulance personnel brought these patients home, the overwhelming majority of them lived alone and managed to regulate their own oxygen just fine. Furthermore, most people, even if they were on oxygen, were on a set amount of oxygen that they didn't have to regulate, and the regulation of oxygen did not move up and down unless directed by a doctor or the very few that had to increase the dosage after standing and walking.

42. The illegal changes that the AMR personnel were required to falsify also involved not having a portable oxygen tank. Often, when a patient called 911 and went to the hospital, their portable oxygen tank was at home and they didn't have one for the trip back home. Fabula and other EMT personnel were routinely required to do a number of rewrites where the family offered to go get the oxygen tank, or already had a portable tank at the hospital. Nonetheless, with these patients, Fabula was instructed: "That's not appropriate care – to let the patient travel with the family," and then he was forced to rewrite the PCR form. The illegal changes that the AMR personnel were required to falsify also involved hip replacements.

43. For a certain period of time after the surgery, the patient was unable to sit at a 90 degree angle and he or she needed a stretcher. Under these circumstances, the patient's transport qualified for Medicare. But, in days or a few weeks following the surgery, the patient began to heal, and soon was capable of sitting at a 90 degree angle. When that person was capable of sitting in a wheelchair or at a 90 degree angle and was doing perfectly fine in recovery, at that point, the patient did not qualify for an ambulance. Nonetheless, the patient was told to get on the stretcher and lie down so that the run qualified. How? Because AMR instructed its ambulance personnel to put into the PCR the old historic information in order to provide the impression that the surgery has just occurred. In this way, AMR "milked" the file for Medicare payments over and over again.

44. The illegal changes that the AMR personnel were required to falsify also involved what is known as a fall risk. Similar to the circumstances with hip replacements, this occurred when a patient was sent to the hospital after a fall and they were traveling back home by stretcher because of the risk of fall. Sometimes a patient was a genuine fall risk. However, if a patient slipped and fell in a shower, then had a hip replacement, and had long since recovered and was capable, or had a long history of walking on their own, AMR nonetheless "stretched" this out, saying that the patient's history of falls did not allow for them to travel by other means. Fabula personally was required to do two of these rewrites that he didn't agree with. Also, most of these patients were either sick, dehydrated or the environment played a role in their fall, and the specific conditions that qualified them for the first transport would no longer be present a while after the fall, particularly with someone right there to assist.

45. Again, each time an ambulance was dispatched by AMR, the ambulance team consisting of paramedics and EMTs was required to prepare an electronic PCR. The PCRs were completed electronically in the following manner:

a. The person identified as "Crew #1 was the paramedic. The person identified as Crew #2 was typically the EMT (unless there were two paramedics on the run.);

b. AMR's procedure required Crew #1 to log in on every run; however, depending on the condition of the patient as determined by Crew #1's on arrival, Crew #2 would then take over the completion of the PCR;

c. The forms were filled out on a laptop computer in the ambulance, and the process involved selecting information that appears in drop down boxes on the computer screen;

d. The paramedic had the initial responsibility to determine the appropriate medical treatment, or whether medical treatment was needed at all;

e. When the paramedic determined that emergency medical treatment was not required and thus the run was not medically necessary - (specific examples of patient transports that did not qualify are detailed in the paragraphs that follow) the preparation of the PCR became the responsibility of the EMT. (And this accounted for the fact that later on, when the fraudulent changes were being ordered by AMR supervisory personnel back at the garage, it was primarily the EMT's who were called upon to make these changes.); and

f. When emergency medical treatment was not required and the conditions of medical necessity could not therefore be met, the trips did not qualify for Medicare reimbursement.

46. Any transport that failed to meet Medicare's medical necessity criteria was not a covered benefit, and therefore was not eligible for reimbursement.

47. But, when medical treatment was not required, AMR nonetheless required its employees, under threat of discontinuing their employment, to change the PCRs to qualify for Medicare reimbursement.

48. The AMR managers couldn't make the changes to the PCRs themselves because Fabula and the other ambulance personnel (paramedics and EMTs) had unique log in passwords that were necessary for filing the PCRs during the ambulance run. So Pierson, Martus, and the other supervisory personnel had to find a way to make the changes that would increase the income stream from Medicare.

49. Again, upon Fabula's and other EMTs' and paramedics' revising or recreating the original electronic PCRs as ordered, the printouts with the handwritten changes were collected by AMR supervisory personnel, like Boyd, Pierson and Martus, and were deposited in a locked box, the contents of which would subsequently be retrieved and destroyed by shredding.

50. AMR's destruction of those records was improper.

51. When Medicare couldn't be billed for a run, Pierson and his subordinates began their scheme. They said, "you have paperwork to complete," and this was where the fraud occurred. They consistently directed ambulance personnel to change PCRs that were completed during a run – the truthful PCRs that were inputted electronically – so that the runs, copied from the paper forms that Pierson or Martus distributed to them back at the garage, would falsely qualify AMR for Medicare reimbursement.

52. They said this when ambulance personnel showed up for work or before they went out for work. The supervisor, when they checked in, got the ambulance personnel to rewrite their PCRs from the day before. Or sometimes after the shift, the ambulance personnel were not allowed to punch out and go home before they redid their PCRs. Or sometimes, even in the middle of a shift, they made ambulance personnel come back to the office to redo paperwork, saying that the "run form" did not "meet company standards" (translation: Medicare wouldn't pay). They called ambulance personnel in, primarily the EMTs, to fill out their

paperwork – the supervisor's paperwork, to redo the paper work with their words - words that would qualify the run for Medicare reimbursement. And so the real meaning behind redoing the paper work was this: "This run is not billable to Medicare, so if you know what's good for you, you'll come back and redo it so it is."

53. Pierson and his subordinates told the EMTs that the PCRs had to "meet company standards." And even then, when an EMT completed and returned this paperwork to Pierson or another supervisor and they still didn't like it, Pierson and the other supervisors had the EMT rewrite it once again.

54. In addition, working in concert with Pierson, employees of AMR also worked at various hospitals served by AMR as liaisons between the hospital and AMR. Nancy Terenzo worked as a liaison. When picking up a patient from a hospital, Fabula and other ambulance personnel were required to secure a Physician Certification Statement ("PCS"). This is a form that Medicare regulations require physicians or registered nurses to complete. But physicians rarely filled them out, leaving it to the nurse. Instead of the nurse, the AMR employee at the hospital filled out the PCS forms for the nurses, and then led the nurses to believe they were signing a form solely for AMR's record-keeping. The nurses did not realize that the forms they were signing were being submitted to Medicare. Most of the nurses signed the PCS forms without reading them, and they had no understanding of what an EMT did. The nurses always asked the EMTs how they should fill out the PCS, and had no clue about what to put in the PCS and why it was important. They waited for the ambulance crew to arrive and ask what was needed to be written. And they then deferred to the AMR liaison at the hospital whom AMR employed. When AMR ambulance personnel could not find a reason why the patient needed to go by ambulance – the medical necessity for the transport that was required for Medicare

reimbursement – the liaison person at the hospital (the AMR employee) looked into that person's medical history in order to find a reason why that person needed an ambulance, and he or she instructed the nurse on what needed to be written in the PCS.

55. Returning to the issue of fraudulent PCRs, Fabula can recall numerous specific runs for which he was ordered to improperly change PCRs.

56. For instance, Kevin Bodiford was the paramedic on an ambulance run in early December 2011 that Fabula was ordered, more than two months later, to come into the office and to input information electronically in order to falsify a PCR.

57. On the run in early December 2011, Fabula was driving and Paramedic Bodiford was the #1 on the run, and so it wasn't Fabula's job to complete the PCR because he didn't do the call. Instead, Kevin Bodiford, the No. #1 on this run was required to complete the PCR.

58. For several weeks after that run date, Fabula witnessed verbal exchanges between Paramedic Bodiford and Pierson in which Pierson repeatedly instructed Bodiford that he needed to revise his original electronic PCR so that it could be submitted to Medicare for payment.

59. But when Bodiford was called back into the garage by Pierson (or one of his subordinates) with the demand that he change the PCR for this particular run, he refused. Every day for a week or two after that date in early December 2011, Bodiford argued with his superiors in the garage and refused to resubmit the PCR as AMR was ordering him to do.

60. Then Bodiford told Pierson that he wasn't the "#1" on that run anyway – that Paul Fabula was the "#1" on that run.

61. And so Pierson came after Fabula and attempted to get him to supply the information on the PCR that would be inputted into the system to qualify the run for Medicare reimbursement.

62. After Christmas, December 25, 2011, Fabula was out on sick leave. Two months later, during February of 2012, Fabula was contacted by email by Pierson, and ordered to return to AMR to recreate an electronically filed PCR from the same run that Bodiford had refused to submit - the same run that was made in early December of 2011.

63. In the emails that preceded Fabula's return to the AMR garage in New Haven, Fabula was instructed to rewrite the electronic PCR because Pierson kept saying in email correspondence that the original had been 'lost'.

64. It is important to note that "losing" a run form was virtually impossible. With the AMR computerized billing system, this could not happen. The PCRs got downloaded into AMR's system and one could not "lose" a run form.

65. Fabula responded by email stating that he wasn't comfortable with this request. He didn't say he was refusing; he just said he didn't believe he could accurately document the information that he was being asked to document.

66. In February 2012, Pierson called him in, and Fabula returned to the garage. Pierson told him: "You should be able to complete the PCR with the information I've provided. I have the patient information. I just need the PCR recreated for billing purposes." Pierson then placed before Fabula information that was (and is) used to determine if a patient needs an ambulance, and also if the patient needs the level of care that AMR is billing Medicare for.

67. Pierson told Fabula to input the information that Pierson put before him in an electronic PCR by copying what was presented to him by Pierson.

68. Since the filings of PCRs are electronic and are submitted via the AMR electronic filing program, the PCR form that Pierson put before him showed Fabula's unique login and his electronic signature. Pierson couldn't make the changes himself, so he ordered that Fabula copy

all of the information from a printout, on paper, that contained all the information that Pierson wanted Fabula to input electronically.

69. All Fabula had to do was copy the information that was given him and input the information into the electronic PCR. Again, this information is the information that the Government uses to determine if a patient actually needs an ambulance and also, if the patient needs the level of care that AMR was billing Medicare for. In effect, Fabula was being asked to recreate an entire electronic PCR form from scratch.

70. Most employees would simply do as they were told, and fill this out with the information that they were told to fill in electronically, so that the run would qualify for Medicare reimbursement.

71. Fabula was being told to transcribe, electronically, information about a transport of "[Transport A] [address]" This was the person that Pierson wanted Fabula to enter into the electronic PCR. December 4, 2011 was the date that Pierson wanted Fabula to include electronically. The "where" was Gaylord Hospital, and the form Fabula was supposed to copy from contained a diagnosis of multiple sclerosis. Again - all of this information is information Pierson was ordering Fabula to enter into the electronic PCR. The information did not come from Fabula; it was information put in front of him that he was instructed to input electronically into the electronic PCR in order to ensure that AMR could bill Medicare for the transport.

72. The narrative in the packet that Pierson wanted Fabula to type into the Electronic PCR was as follows: "Patient with history for advanced stage multiple sclerosis and is bed confined with severe contraction of the hands, arms, hips, legs and feet. Patient going to Gaylord

Hospital for bactofin trail/ Testos procedure. Patient also with decubilis ulcer on lower back. Patient had no changes en route to facility. Patient left in room with staff."

73. The excerpted words "bed confined with severe contraction of the hands" would be enough to qualify the run for "medical necessity," and therefore reimbursement by Medicare.

74. These words were not Fabula's words. He would never put "bactofin trail/Testos procedure" into a PCR; in fact, he didn't even know what these words meant.

75. The form also said - "Time at Scene: 6:43.05" then "Time at Pt Side: 6:44.05." This also reflects a deception and that the information didn't come from Fabula. No EMT is at the patient's side one minute after arrival. He needs between 5 and 10 minutes just to unload all his equipment from the ambulance.

76. Further, according to the notes put before Fabula to input electronically, the patient [Transport A] [address] resided on the 3rd Floor which would require even more time, certainly more than the 1 minute in the bogus information that Pierson had placed before Fabula. Fabula was being asked to falsify a document in order to have Medicare pay.

77. AMR thus was making it the task of Fabula, as it was doing with all the other ambulance personnel, to falsify reasons why the person's transportation could be coded on the PCRs in a manner that would result in "medical necessity" in order to qualify for Medicare reimbursement.

78. In a letter from his supervisor dated March 1, 2012, Fabula was threatened with termination with the following words, "Please contact this office immediately to arrange a time for reconciliation and transmission of this EPCR. Failure to do so will result in corrective action up to and including termination."

79. Fabula's refusal to sign and to change the PCR was the first time he'd stood up for himself and said no, he was no longer going to do this.

80. For finally taking a stand for the very first time, and for refusing to do something that he knew violated Federal statutes, rules, and regulations governing truthfulness of what was being certified in the PCRs, Fabula was placed on administrative leave "until he completed the document." He was told by Pierson that his refusal "was a direct violation of company's standard operating procedure."

81. Although he was not formally terminated at the date of filing of the Complaint, but rather placed on an unpaid administrative leave, Fabula found himself in the "limbo" status of a *de facto* termination.

82. Fabula discovered that the threat of termination was real, and, although he was kept on the books of AMR well into 2012 in an "on suspension" status, December 25, 2011, was his last official day of employment at AMR – the last day he was paid for his work.

83. AMR was thwarted by Fabula for the very first time, and was not successful in submitting its claim for payment to Medicare for the transport that is supposed to have occurred on December 4, 2011.

84. On another occasion, Fabula arrived at a hospital (following a request for a transport), to find a patient sitting on a stretcher saying, "Take me home." Fabula went to AMR's hospital liaison (a woman named Nancy) and said, "Why does this person need an ambulance?"

85. Nancy responded: "Oh, this patient has cancer." Fabula then said, "The patient doesn't get Medicare for this," so Nancy put down dementia. Then when Fabula said, "Dementia is not covered unless the patient is violent or wandering," Nancy went back and

found something in the hospital record about an incident 3 years ago. "The patient has violent tendencies," she said, and put down that, "Today, the patient is violent."

86. Often, the EMTs had patients with no recent medical history that would be reason for an ambulance to transport them. When this happened, they were "encouraged" to call into the dispatch center. The dispatch center was (and is) located in New Haven and it dispatches for all of Connecticut. Fabula personally spent approximately 80 hours in the dispatch center and saw how it operates. The dispatch center has all the patients' histories and records from all across Connecticut on file. This was done to "see things from another perspective."

87. While at the dispatch center, Fabula witnessed hundreds of employees calling in for the "Medical necessity reason." The Dispatch Center then looked into the patient's past history to find a past reason for the transport, one that would qualify for Medicare reimbursement. And if there were any run forms kicked back to the dispatch center, they were sent back to the "team" and processed there in the same manner described earlier in this Third Amended Complaint.

88. Regularly, when Fabula picked up patients in Waterbury, the nurse at the hospital simply left a signed PCR on the desk with no information filled out, and Fabula along with the ambulance personnel were instructed by management to fill this in themselves with a medically necessary reason for the run.

89. When Pierson was assigned the supervisory position of quality control, his job was to oversee the entire billing process. Even when an EMT said to him, "This patient didn't need an ambulance," it didn't mean anything to him, because he was always trying to figure out a way to change the documents.

90. Sometimes, even in the middle of a shift, Pierson, Martus, or one of their subordinates made the ambulance personnel come back to the garage to "redo paperwork," saying that the "run form" did not "meet company standards," or "you've got to fix these run forms," or "you have to redo this call." And so the ambulance personnel then entered electronically the paperwork revisions that the supervisors placed before them. The electronic entries were not their own, and not the truthful information that was originally recorded about the patient when the run was made, but were the supervisor's words - words that qualified the run for Medicare reimbursement.

91. Thus, beginning with Boyd, down through Pierson, then to Martus – all were instrumental in keeping the pressure on all the EMTs and paramedics to falsify the PCRs.

92. And so the real meaning behind "redoing paper work" was this: "The run is not billable to Medicare, so if you know what's good for you, you'll come back and re-do it so it is." Both expressly and implicitly, Boyd, Pierson, Martus and their subordinates, informed Fabula and other ambulance personnel that their continued employment depended on following these - their supervisors' – instructions to falsify PCRs.

93. Beyond himself, Fabula can also identify other AMR personnel with knowledge of fraudulently billed runs.

94. Oliver Tatum was a paramedic Fabula worked with occasionally while at AMR. On September 11, 2011, they were working together, and during this shift Oliver was vocal about his displeasure regarding AMR forcing rewrites of PCRs. He and Fabula were friends, and he came to Fabula's house and expressed his frustrations, explaining that this was one of the reasons why he was moving to Oregon. He was very uncomfortable with AMR "putting their

words on our paperwork." Tatum was also the person that started Fabula on the line of thinking that what AMR was asking ambulance personnel to do might be illegal.

95. Ronald Deline was an EMT who became a paramedic before Fabula left AMR. Fabula's last day working was with him, December 25, 2011. During this shift, Deline was in trouble for submitting paperwork that was not reimbursable by Medicare. This was also the date Fabula had dislocated his shoulder at work. Deline wanted to go home because he was angry that AMR was "trying to tell him the condition of his patients."

96. Paul Zadrozny was a dispatcher at AMR, now a firefighter in Topeka Kansas. On Dec 16, 2011, Zadrozny asked Fabula to call into dispatch. There was a transfer that was "long distance" and he wanted to know if Fabula wanted it. These trips were sought after by EMT personal because they took up a good part of a shift and they were usually easy work. Zadrozny had to "clarify" with Fabula that he would be required to fill in the paperwork properly to ensure Medicare would pay the bill. AMR wanted Fabula to write "patient is unable to sit at a 90 degree angle due to hip fracture." However, the hip fracture and replacement was over 5 years earlier, and the patient had already fully recovered. That patient went from New Haven, CT, to Guilford, CT.

97. Amy Baitch is a paramedic Fabula worked with in AMR's Milford division. On December 14, 2011, she and Fabula transferred two patients as 911 emergency calls that were actually inter-facility transfers. They had to be seen at the hospital by their doctors. The first was transported from 195 Platt Street, Milford, CT, to Milford hospital. The patient was alert and oriented, able to stand and pivot, and had no reason to travel by ambulance except for the fact that AMR placed the calls as "911," rather than standard transport, and thus Medicare was billed for the transport.

98. The second run with Baitch was from 225 Amity Road, Woodbridge, CT, to Yale-New Haven Hospital. This patient could have traveled by other means, but the call was placed as a 911 call rather than a scheduled transport and on information and belief, Medicare was billed.

99. On December 7, 2011, Fabula received a day's suspension for not completing three "parked" PCRs from May. He was forced to fill out these three forms with information provided to him by AMR, or not return from suspension. He completed them and returned to work the next day.

100. Douglass Gladstone was an EMT that Fabula worked with on December 4, 2011. During that shift they had to assist a crew with transporting [Transport B] to the hospital. [B] mentioned in further detail elsewhere, had no medical reason to be sent to the hospital, he simply wanted to go there. AMR instructed Fabula to write down [B's] previous surgeries to justify his transport to the hospital. [B] was able to walk himself to the stretcher, and climb on unassisted. He had no medical cause for transport.

101. On October 17, 2011, Fabula transported a patient from [address] to Pequot Health Center. The patient actually did need an ambulance to travel. However, on the way to the destination, the transport was cancelled because it was the wrong date for the patient's appointment. AMR still required Fabula to complete a return trip PCR, as if the patient had been transported twice, when in fact he was only transported one time. Fabula's supervisor informed him that he could just tell the nurse at the nursing home "to sign twice." She was tricked into signing as though she was receiving the patient at the health center.

102. William Shick was a paramedic. On July 7, 2011, he and Fabula were sent on several 911 calls for patients that did not actually require an ambulance. Two weeks later on

July 22, four of the PCRs from July 7 were waiting for Fabula at the operations desk when he punched into work. These patients were on Medicaid and Fabula was told he had to write in previous surgeries and injuries to justify their need for transport. One of them that was a middle aged women living in state housing in New Haven, CT, who wanted a ride to the hospital because she felt she could "skip the line" if an ambulance brought her in. She was going in for a chronic allergy issue. Another was from the homeless shelter in New Haven, and called 911 because he didn't feel like he should have to buy cough syrup.

103. Rich Acampora was an EMT who complained to Fabula in 2011 how it had gotten really bad, saying, "They want you to write what they want on the form every time..."

104. Rob Phelan is an EMT and he was required more than once a week to sit down an hour after his shift had ended just to re-input the PCRs in order to make the changes he was required to make. Fabula thought Phelan looked like he was going to cry one time with all the paper work he was ordered to redo. Then, one day, Phelan said to Fabula, "If they're going to make me rewrite," he said, "and they're not going to let me leave unless I finish the paper work, I'm going to make them pay." Phelan began to "game the system." He was a full time employee who got time and a half for over time, so he waited for all the changes to pile up, and then, after his eight hours of work, he would stay to redo all the paperwork they wanted him to do, and was paid overtime for doing so.

105. Tom DellaValle was a dispatcher, and he was someone who was always aware of which runs "needed" an ambulance. So on occasion Fabula called DellaValle saying, "I have a patient and I'm trying to figure out why she needs an ambulance," and DellaValle, being a dispatcher who had access to the patient's records, said, "Well, she had a hip fracture three years

ago." So Fabula wrote on the PCR form, "Hip fracture," as though it had just occurred, and, on information and belief, the run was processed for Medicare reimbursement.

106. Several EMTs were suspended for not completing paperwork the way Pierson and AMR wanted them to. Ronald Deline, Heather Gebhardt, Michael Mitchell, Erica Nastri, Chris Elwell - all were EMTs who were suspended one or two days for not completing the paperwork in the manner that would qualify for Medicare reimbursement. But then, they all returned to work shortly thereafter when they "followed orders" and did what they were told.

107. Particularly, egregious billings involved transports provided for [Transport B] (mentioned earlier) and [Transport C]

108. [B] (now deceased) of [address] in New Haven, was a grossly overweight man and a diabetic, and he called 911 for an ambulance on a daily basis - six dozen times during 2011 - to bring him to his medical facility - for his insulin. Paul Fabula was directed, under threat of being put on unpaid leave, to change and falsely certify the electronic entry of the PCRs in order to say that [B] had difficulty remaining in an upright position in order to qualify [B's] runs in the ambulance for Medicare/Medicaid reimbursement. Fabula did as he was ordered, and upon information and belief they were submitted to Medicare for payment.

109. [C] was a dialysis patient, who, initially, when AMR first began to transport him, could not stand and walk; but then, after a short period of time, he was able to walk and to sit up on a stretcher. He received 6 trips a week. He himself even questioned why he was being transported by ambulance for dialysis, from [address] to Branford dialysis. AMR arranged to have [C] transported to and from his dialysis appointments three times a week all summer long in 2011.

110. In addition to the above-identified runs that AMR fraudulently submitted to Medicare for payment, all of AMR's other false claims based upon improper revising or recreating of Fabula's PCRs can be readily identified by, and from, the existence of multiple versions of electronic PCRs for any particular run that has been submitted to Medicare for payment – *i.e.*, information within the possession, custody, or control of AMR.

111. AMR's improper revising and recreating of PCRs was not limited to Fabula.

112. Indeed, Fabula witnessed all of his fellow EMTs and paramedics being subjected to the same scheme on a daily basis.

113. He witnessed this scheme not only in the New Haven branch, but also at AMR's branches serving Fairfield County, Greater Hartford/Northeast Connecticut, and Waterbury/Farmington Valley.

114. As with Fabula's own improperly revised or recreated PCRs, his colleagues' improperly revised or recreated PCRs can be readily identified by, and from, the existence of multiple versions of electronic PCRs for any particular run that has been submitted to Medicare for payment – again, information within the possession, custody, or control of AMR.

Scope of the Damages Claimed in New Haven, Waterbury, Hartford, and Bridgeport

115. All of the Ambulance personnel – the EMTs and the Paramedics – were prohibited from making unauthorized entrances into the administrative building of AMR in New Haven where all the billing was taking place. While AMR required that its EMTs and Paramedics personally certify whether ambulance runs were medically necessary – whether they were actually medically necessary or not – AMR did not invite or require either Fabula or any of its other ambulance personnel to participate in the billing procedures. Restricted to the "garage" and the "window" where they punched in and punched out each day, they were not involved in

billing Medicare or Medicaid for their ambulance runs. This was a task delegated to those in the billing department at AMR. As a result, specific information about AMR's submissions to Medicare - in the fraudulent PCRs by AMR emergency personnel - is information particularly within the knowledge and control of, and access to, the defendant, AMR, and not accessible by any paramedics or EMTs such as Fabula.

116. AMR New Haven has a department called "TAD." TAD is the billing quality control unit, and the AMR employees in "TAD" review the paperwork as it comes in after the runs, and they then track the trend of what Medicare pays for and what Medicare denies. Pierson, the person in the New Haven operation most responsible for directing the false submission of claims to Medicare, was promoted to a position that oversees the TAD department.

117. All the contacts ambulance personnel had with the defendant AMR, including Fabula and all the EMTs and paramedics - at the beginning, at the ending, and throughout their working day or shift - were solely in the garage, where the EMTs and the paramedics punched in and were handed out the gear to resupply the ambulances, and punched out at the end of their shifts.

118. In May of 2011, while Fabula was employed at AMR's subsidiary in New Haven, and while AMR was submitting the false claims as described above, AMR entered into a Corporate Integrity Agreement ("CIA") with the Office of the Inspector General of the Department of Health and Human Services. The CIA included specific, detailed nationwide obligations required of AMR in order to fulfill the terms and conditions of the agreement. AMR promised to promote compliance with statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)).

119. In the CIA, AMR also represented that, prior to its effective date, it had established a corporate compliance program that "applied to all AMR subsidiaries and facilities." Further, that "AMR's compliance program include(d) written policies and procedures, an education and training component, mechanisms for the ongoing monitoring and auditing of AMR operations to assess compliance, mechanisms for employees and agents to report incidents of noncompliance in an anonymous way, disciplinary actions for individuals violating compliance policies and procedures, and oversight of the compliance program by the AMR Compliance Officer and Compliance Committee."

120. At Fabula's level of the operation in New Haven and Connecticut, there was no evidence that any single one of these promises and obligations were being fulfilled or kept. In New Haven, just the opposite was occurring – where the CIA called for "disciplinary actions for individuals violating compliance policies and procedures," Fabula was the one being disciplined (and soon to be terminated) for attempting to get AMR not to commit fraud, and not to violate "compliance policies and procedures."

121. In the same nationwide agreement, the CIA went on to include specific, detailed obligations of AMR in order to fulfill all of its obligations – nationwide – under this agreement.

122. Again, at Fabula's level of the operation, where AMR was obligated, during the term of the CIA, to "comply with the integrity obligations enumerated in this CIA," Fabula saw absolutely no evidence that any one of the specific promises made, and obligations undertaken, by AMR – all outlined in detail in the 31 pages of the CIA – were being fulfilled or kept.

123. The CIA did not spell an end to fraudulent billing practices, but instead created the insidious implementation of a more determined and sophisticated means of submitting false claims. And so Fabula is not claiming that AMR violated the CIA, but instead used the CIA,

with Boyd as its agent in the Northeast and particularly in the New Haven operation, to implement the nationwide electronic changes in the billing procedures following the signing of the CIA – which changes on information and belief brought about substantial increases in the false and fraudulent billings to Medicare.

124. As noted earlier, Boyd was the coordinator for the northeast region. He is/was a member of AMR's (nationwide) Clinical Leadership Council (CLC). Using AMR's national clinical data in conjunction with contemporary medical literature, he provided details on how the CLC was tasked with identifying and implementing "clinical excellence strategies, programs and standards for AMR."

125. Among the projects of the CLC was the creation of "a documentation guide and online training program that educates AMR caregivers about the company's documentation standards." Boyd boasted to ambulance personnel at the New Haven facility that included Fabula about how he was the one who, at the national level, was responsible for designing and implementing features of the new billing program that were included in the new laptops provided throughout the entire country following the signing of the CIA, with the specific goal of increasing Medicare billings.

126. AMR was not in the habit of training its employees – Fabula and others – to recognize medical conditions in a patient that would require and qualify the patient for an ambulance for safe travel, or teach proper documentation for billing and patient care accuracy. But following the signing of a CIA, AMR used this CIA to shield its continuing practice of defrauding the government and maximizing its reimbursement of funds to which it was not entitled.

127. In early summer of 2011, following the signing of the CIA, Fabula and all AMR ambulance personnel were required to attend companywide sessions for training to address AMR's "new documentation policies" that, on information and belief, also were being given to personnel in all of AMR's 2,100 branches across the United States.

128. The theme of the training program that was stated to Fabula along with the other ambulance personnel was this: "We need to be a little clearer on our documentation." The actual theme was the goal of an exponential increase in billings to Medicare.

129. The Coordinator for the Northeast Region of the United States, Boyd, worked out of the New Haven Office. As noted, Boyd was a member of AMR's (Nationwide) Clinical Leadership Council.

130. Boyd advised Fabula that the New Haven subsidiary was second in revenue among all of AMR's facilities in the United States, and that because of its heavy volume, New Haven had been allowed by the national corporate office of AMR for years to maintain the level of having a relatively low percentage of its ambulance runs being billed to Medicare.

131. According to Boyd, prior to the signing of the CIA, AMR in New Haven had approximately 40% of its runs being reimbursed by Medicare. During one of the training sessions in New Haven, Boyd told all the ambulance personnel, including Fabula, that every division of AMR had policies and training in place that was focused on increasing the billing reimbursement from Medicare, and that "While New Haven was at around 40% for collecting from Medicare, other divisions were closer to 70%."

132. The signing of the CIA was used by AMR as the springboard - the premise, the instrument, and/or the excuse - for implementing a program for increasing the percentage of Medicare reimbursable ambulance runs. Following the signing of the CIA, the policy from

AMR at the corporate national level, on information and belief and as communicated by Boyd's subordinate Pierson, was to increase the New Haven subsidiary's Medicare reimbursements to 70% of its runs. Pierson's sole responsibility was, and on information and belief, still is at the present time, to see that Medicare gets billed for as many runs as possible and to increase the billings to Medicare from 40% to 70%.

133. Before Pierson was appointed to this position, Fabula, along with all the other ambulance personnel was required to falsify PCRs but much less frequently. "Poor documentation leads to calls not being paid for," Boyd told New Haven ambulance personnel, and the new training model was based on how to "improve" the numbers by fraudulently increasing the number of PCRs that could be submitted for Medicare reimbursement.

134. During company training on the new laptops in the spring of 2011, Fabula and other ambulance personnel at the New Haven facility were told that the purpose of the new software program that Boyd had a hand in designing, was to help "guide" them to prepare "better" PCRs. Ambulance personnel understood "better" to mean getting more of the ambulance runs to qualify for Medicare reimbursement.

135. Boyd instructed Fabula along with other ambulance personnel how Medicare would pay for medical conditions or illnesses only when key words and descriptions "are in your (Electronic) PCR." Fabula understood Boyd to be referring to the concerted effort by corporate management to get ambulance personnel to falsify PCRs so that, by lying about the terms and conditions of the CIA at every opportunity, the runs would be Medicare reimbursable.

136. During company training on new laptops, the paramedics and EMTs were told that the new Software would help "guide" them to prepare "better" PCRs (Interpretation: "better" = runs that qualify for Medicare payment). Boyd stated to a class of ambulance

personnel (that included Fabula) that for years every division of AMR had policies and training in place that increased billing payments from Medicare. He talked about how "Medicare will pay for medical conditions or illnesses only when key words and descriptions are in your run form." He then instructed the class how, by following "companywide standards," the ambulance personnel could tailor the run forms and go about "reaching the 70 to 80% levels."

137. AMR sent a staff MD from corporate with a PowerPoint presentation. The instructions via the PowerPoint presentation demonstrated how to implement the additional applications of the electronic reporting system.

138. The newly adopted program not only forced the up-billing of paramedic services, for example, but also, the PCR would not meet the requirements to transmit if all the PCR fields were not filled out and completed. And these fields, once clicked or checked, "auto filled" the requirements necessary to get Medicare to pay. Thus, the new computer application was created to get additional dollars from Medicare

139. Boyd then instructed the class how, by following the new companywide standards, Fabula and other ambulance personnel could falsify by "tailoring" the PCRs to reach the 70% to 80% levels of Medicare reimbursement for AMR.

140. EMS (Emergency Medical Services) guidelines stated that both AMR personnel in the ambulance must sign on all PCRs, and AMR capitalized on its newly renovated electronic PCR system (EPCR) by programming its software to bill at the highest level of care possible in order to qualify for Medicare reimbursement.

141. As one single example among many, AMR mandated that, in order for each and every run form to be completed, there needed to be a "paramedic assessment." Boyd boasted that

as a member of AMR's CLC, he'd been one of the designers of the nationwide application of the new electronic PCR filing system.

142. The new electronic filing system included a requirement that the box for "paramedic assessment" had to be checked for every run, and that no PCR could go through the system and be processed without checking Advance Life Support ("ALS") assessment. If this was not checked, the form would not get processed.

143. A paramedic assessment occurs when an electrocardiogram ("EKG") monitor is put on the chest. A paramedic intervention occurs when the patient is hooked up to an intravenous feed. A paramedic assessment is billed to Medicare at around $1,200, and a paramedic intervention is billed to Medicare at around $1,500.

144. The regulations required that, for an "ALS assessment" to occur, the patient must receive advanced medical monitoring or care with heart monitoring, medications, advanced airways - all services the paramedic was trained to provide, and services that Medicare would pay for.

145. Thus, checking off "paramedic assessment" in the electronic PCR was a certification and representation by the paramedic that a paramedic assessment had in fact been performed, thus allowing AMR to receive an amount of $1,200 in the bill that was submitted to Medicare.

146. Following the CIA, AMR implemented programming in the software, wherein, simply because a paramedic was present in the ambulance (and they are present in the ambulance over 95% of the time) the computer automatically defaulted to "paramedic assessment." If the box was not checked - and the computer instructed that it had to be - the PCR could not be completed.

147. Another result of the new electronic programming was that when it was determined that a paramedic was not needed, this judgment, in and of itself was considered to be a 'paramedic assessment,' and the program automatically defaulted on every run form to check off that a "paramedic assessment" had been performed. If, for example, the patient had called 911 and was only going to the hospital to pick up aspirin, the fact that the patient did not need the services of a paramedic at all was still, with the new program, determined to be a "paramedic assessment," simply because a paramedic was present in the ambulance. The result was that Medicare automatically was billed at the $1,200, because, under the new electronic billing application, "paramedic assessment" was checked on the run form.

148. An additional feature of the new software program implemented after the CIA, was one that described each and every patient as "bed confined" - by automatically inserting a "Yes" in the corresponding data field on the electronic claims form, irrespective of the actual physical condition of the patient, even though information contained on the providers' own run reports frequently indicated that the patient was not bed confined. Although the computer program would not autofill in "bed confined," it would require certain fields to be filled in before it would transmit the PCR - such as paramedic assessment - even when this was not needed or necessary.

149. Thus, under the rubric of "reform" through the implementation of the CIA, the process of over-billing was institutionalized in AMR facilities.

150. As noted, before Pierson took over, and before the CIA was signed in May of 2011, there were maybe 1-5 printouts waiting at the window every day for the employees who were working that day - or about 2 or 3 PCRs from all the crews working that shift - that needed to be rewritten.

151. But after the signing of the CIA, Pierson and the others had their marching orders on how AMR New Haven might increase the Medicare billings. After Pierson attended AMR conferences, he told the ambulance personnel – the paramedics and the EMTs – that what he was doing was corporate policy, and on information and belief, Pierson was paid based on the calls that he's completed, which meant that his pay was based on how many calls AMR got paid for. And his job was to be certain that the paperwork led to increased payments from Medicare.

152. Now when Fabula showed up for his shift every day, he saw a pile of 30 PCRs waiting at the window – PCRs that the supervisor said needed to be redone.

153. There were, on information and belief, 60-70 shifts every weekday (with Sunday being a day with no dialysis centers open and very few calls, and this day is not in the equation.)

154. Shifts of ambulance personnel varied from 6 hours to 12 hours. With the 12 hour shifts doing 8-10 calls, and the 6 hour shifts doing 4, the number of calls totaled around 5 per person, per shift, per day. Doing the math, this would mean, conservatively 300 to 350 calls per day at the AMR New Haven branch.

155. The AMR Training Manager in New Haven – the Regional Training Manager, Boyd – said that the New Haven AMR facility was one of the top 5 busiest AMR facilities in the nation.

156. On May 16, 2012, Medicare through National Government Services and CMS responded to a Freedom of Information request that provides the details on billings to Medicare through the New Haven AMR operation. The documents it produced indicate that AMR New Haven performed a total of 344,867 Medicare/Medicaid runs during the years 2010 through to 2011 - during the period of time when Fabula was employed as an EMT. This computes out to

172,433 Medicare/Medicaid runs each year that were generated solely by the New Haven Branch of AMR.

157. According to Regional Training Manager Boyd, these New Haven numbers represented some of the largest number of Medicare/Medicaid transports in the country. But the percentage of Medicare/Medicaid billings for these patient transports was one of the lowest according to Boyd, and Boyd told Fabula and other EMTs that, while New Haven had the largest percentage of Medicare/Medicaid patients in the country, its Medicare reimbursement rate for ambulance runs when the CIA was signed was at the 40% reimbursement rate. Boyd instructed the EMTs and paramedics that the New Haven branch's goal was to get to the 70% level of billings to Medicare, and, on information and belief, this was the basis for the exponential uptick in the orders from management to make the changes in the PCRs.

158. Based on Fabula's experience as an EMT, while working an average of 50 hours per week and making between 30 to 50 ambulance runs a week, fewer than 10 of those 30 to 50 runs per week involved picking up patients who met the criteria of medical necessity. Calculating Fabula's 30 to 50 runs per week to an average of 40 runs per week, and with Fabula's estimate that fewer than 10 runs per week were reimbursable, this calculates to the number of 25% of the ambulance runs in Fabula's experience in New Haven that were legitimately reimbursable by Medicare.

159. When Fabula's experience is projected onto all of the Medicare runs in the New Haven office - the documented 172,433 Medicare/Medicaid runs each year 25% of this number produces 43,108 of the 172,433 runs per year in the New Haven office that were legitimately billed to Medicare.

160. Inasmuch as Boyd advised Fabula and the other EMTs and paramedics that, prior to the signing of the CIA AMR in New Haven (already) was successfully billing 40% of its runs to Medicare. AMR already (pre-CIA) was cheating the government on 15% of its runs. This means that 15% of the runs - a "lowball" percentage - were being billed to Medicare that shouldn't have been billed to Medicare, which calculates to 25,864 ambulance runs during one year, in 2010, that were billed to Medicare that shouldn't have been.

161. Putting the conservative figure of $500.00 being charged to Medicare for each run, the total calculates to a figure of $12,932,475 that Medicare paid that it shouldn't have paid during one year in New Haven. This number increases exponentially when the paramedic assessment figure of $1200 mentioned earlier is taken into consideration and calculated into this equation

162. Furthermore, the number of $12,932,475 for one year is a *rock bottom* calculation just for the New Haven branch alone, and also before the CIA goal of going from 40% to 70% was implemented in 2011.

163. After someone complained about the incredible increase in the number of PCRs that had to be "corrected," and the stack of run forms that he had to fill out, Boyd was asked, in 2011, if the new (but illegal and fraudulent) way of completing the PCRs "was working" – whether the effort to increase Medicare billings (no matter by what means) "was working." Paul Fabula heard Boyd respond, "Hey, it's working."

164. Thus, after the execution of the CIA that went into effect in May 2010 that became AMR's national policy, and after the settlement of a False Claims Action that involved overbilling that occurred in the Brooklyn facility, one would think, now that the overbilling had been dealt with and corrected – not only in Brooklyn, but nationally, and that there would be

fewer unqualified-for-Medicare runs being paid for by the Government, and, as a result, one might also expect a diminution in the dollar amounts of billings being paid by Medicare.

165. But this did not happen, not in Connecticut.

FIRST COUNT: AMR'S FALSE CLAIMS ACT VIOLATIONS (31 U.S.C. § 3729(a)(1) and 31 U.S.C. § 3729(a)(2))

166. The allegations contained in the preceding paragraphs are incorporated by reference as if fully set forth herein.

167. The False Claims Act, 31 U.S.C. § 3729 as amended by the Fraud Enforcement and Recovery Act of 2009, Sec. (a) provides, *inter alia*: any person who:

> (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
>
> (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim . . . is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, plus 3 times the amount of damages which the Government sustains because of the act of that person.

The Medicare Program

168. In 1965, Congress enacted Title XVIII of the Social Security Act ("Medicare" or the "Medicare Program") to pay for the costs of certain health services and health care.

169. HHS is responsible for the administration and supervision of the Medicare program. HCFA is a division of HHS and is directly responsible for the administration of the Medicare program. To assist in the administration of Medicare, HCFA contracts with "fiscal intermediaries." 42 U.S.C § 1395h. Fiscal intermediaries typically are insurance companies that provide a variety of services, including processing and paying claims and auditing bills that have been submitted for payment.

170. The Defendant AMR submitted claims directly to designated agents of the United States Government for reimbursement or to its assigned fiscal intermediaries based upon the number of visits and treatments by what it claimed were Medicare beneficiaries.

171. Providers receive payments on these claims and the providing facility must submit its billings to its fiscal intermediary and/or directly to designated agents of the United States Government so that the claims are made to the Federal Government.

172. HCFA requires providers of services such as AMR, as a prerequisite to payment by Medicare, to submit accurate and detailed information in accordance with HCFA regulations promulgated in the Medicare Healthcare Benefits Policy Manual. The accuracy of the submissions by providers of services such as AMR form the basis for the determination by Medicare whether the provider is entitled reimbursement by the Federal Government.

173. In order to complete the billing submissions, the medical service provider (here, AMR) is required to review and submit information about the condition of patients, and the emergency or non-emergency medical services provided. This information submitted by AMR that is the subject of this action was certified as accurate.

174. Every such billing submission by AMR contained a "Certification," which was required to be signed electronically and submitted by the chief administrator of AMR, or by a responsible designee of the administrator. Lindsay Martus, an employee of AMR, was the designee responsible for submitting the certified forms to the Government or to its fiscal intermediary.

175. Initially, the submissions included one certification from AMR, and one from the medical provider. Later, two signatures were required from each, and Ms. Martus was in charge of submitting the forms.

176. The certification provisions require the provider to certify, that to the best of the provider's (AMR's) knowledge and belief, the bills being submitted are the true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions.

177. Thus, to comply with the certification requirements and in order to get paid by Medicare, the provider is required to include data and information in accordance with applicable instructions.

178. The provider must certify that the filed information is (1) truthful, *i.e.*, that the information contained in the report is true and accurate, (2) correct, *i.e.*, that the provider is entitled to reimbursement in accordance with applicable instructions, and (3) complete, *i.e.*, that the billing is based upon the provider's accurate description of the care rendered and by whom it was rendered.

179. The Medicare program depends heavily upon the truthfulness of providers in completing their billing information, and HHS and HCFA both condition payments on the truthfulness of the certified statements related to billing submissions, and relies on this information in determining the provider's payments.

180. HCFA considers any billing submission containing a false statement that affects reimbursement to be invalid.

181. AMR cheated the United States government and its citizens by submitting false claims and false statements in its billing for Medicare and Medicaid reimbursement.

The Medicaid Program

182. Medicaid is a joint federal-state program that provides health care benefits for certain groups, primarily the poor and disabled. The federal government involvement in

Medicaid arises from providing matching funding and ensuring that the states comply with minimum standards in the administration of the program.

183. Medicaid's Medical Assistance Program provides financial coverage for a wide array of necessary medical services for the poor and disadvantaged. 14 U.S.C. §§ 1396, 1396D(a), *et seq*. Since 1965, the Social Security Act, Title XIX, has funded Medicaid. The primary purpose of the Medicaid Act was to provide access to, and provide improvement of, the quality of care for indigent individuals who were unable to pay.

184. While participation in Medicaid is not required, a state choosing to participate in Medicaid must devise a state plan for medical assistance according to federal guidelines and must receive approval of the plan from HHS.

185. The federal Medicaid statute sets forth the minimum requirements for state Medicaid programs to qualify for federal funding, which is called federal financial participation ("FFP"). 42 U.S.C. § 1396, *et seq*.

186. Each state requires that an authorized agent of the medical service provider expressly certify that the information and data contained within the submitted billings are true and correct.

187. The certified Medicaid information and data contained within the submitted billings is relied upon by the federally funded Medicaid programs to determine the reimbursement to which the medical service provider is entitled.

188. False or incorrect data or information in the medical service provider's billing, here, AMR's billing, necessarily causes the submission of false or incorrect data or information to the state Medicaid program.

189. Where a provider submits the billing statements to Medicaid through Medicare, a false certification on the billing to Medicare necessarily results in a false certification to Medicaid.

190. Where a provider submits a Medicaid bill that contains the same false or incorrect information contained in the provider's bill to Medicare, it is submitting false statements and false claims for reimbursement from Medicaid.

191. The United States thus is damaged whenever a state Medicaid program has been damaged by a provider's (in this case, AMR's) submission of false claims and false statements because the United States funds a portion of each state's Medicaid program.

192. Where appropriate (*i.e.*, when the facts alleged with regard to the fraudulent billing of services apply to both Medicare and Medicaid), the term "Medicare" may be used interchangeably with "Medicaid."

193. AMR has knowingly presented or caused false records or statements to be presented to the United States for the purpose of getting a false or fraudulent claim paid or approved by the Government, in violation of 31 U.S.C. § 3729(a)(1).

194. AMR has knowingly made, used or caused to be made or used false records or statements material to false or fraudulent claims to the United States for the purpose of getting false or fraudulent claims paid by the United States in violation of 31 U.S.C. § 3729(a)(2).

195. AMR knowingly, systematically, and/or with willful disregard submitted claims for payment for ambulance transports that failed to meet Medicare and Medicaid coverage criteria with regard to medical necessity, and thus submitted false claims in violation of the False Claims Act.

196. The false claims resulted in the Defendant AMR's receiving millions of dollars in payments from the Government through Medicare and Medicaid to which it was not entitled, all resulting in substantial loss and damage to the United States.

WHEREFORE, as to the **FIRST COUNT**, the Trustee in Bankruptcy, on behalf of the United States of America, the Bankruptcy Estate of Paul Fabula, and Paul Fabula, individually, hereby, prays:

a. That this Court enter judgment against Defendant AMR in an amount equal to three times the amount of damages the United States Government has sustained because of Defendant's actions, plus a civil penalty of $5,000 - $10,000 for each action in violation of 31 U.S.C. §3729, and the cost of this action, with interest, including the cost to the United States Government for its expenses related to this action;

b. That the Relator Trustee in Bankruptcy be awarded all costs incurred, including reasonable attorneys' fees;

c. That, because the United States of America has not intervened in this action, the Relator be awarded an amount for bringing this action that the Court decides is reasonable for collecting the civil penalty and damages, which shall be not less than 25% and not more than 30% of the damages or settlement proceeds recovered by the United States of America;

d. That the Relator be awarded prejudgment interest;

e. That a trial by jury be held on all issues; and

f. That the United States of America and Relator Trustee in Bankruptcy receive all other relief, both at law or equity, to which they reasonably may be entitled.

RELATOR DEMANDS A TRIAL BY JURY ON ALL ISSUES SO TRIABLE.

Respectfully submitted,
RONALD I. CHORCHES,
In his capacity as BANKRUPTCY TRUSTEE,
By his attorneys,

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CERTIFICATE OF SERVICE

I hereby certify that on April 24, 2015, a copy of the foregoing Motion for Substitution of Party was served via ECF on all counsel of record.

/s/ Anthony R. Zelle
Anthony R Zelle