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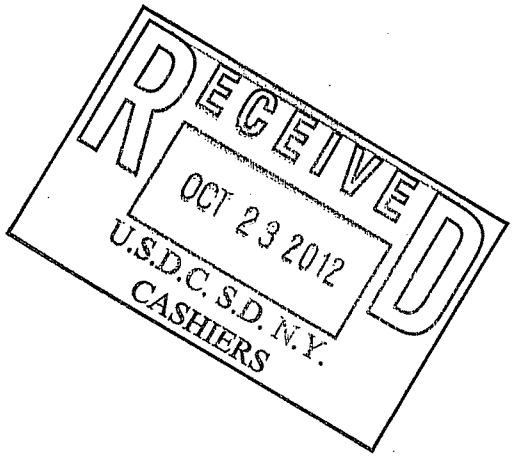

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA and STATE OF NEW YORK ex rel. JOHN DOE, Plaintiff, - against - WESTCHESTER COUNTY HEALTH CARE CORPORATION, Defendant.	11 Civ. 5329 (CM)
UNITED STATES OF AMERICA, Plaintiff, - against - WESTCHESTER COUNTY HEALTH CARE CORPORATION doing business as Westchester Medical Center, Defendant.	COMPLAINT-IN-INTERVENTION OF THE UNITED STATES OF AMERICA JURY TRIAL DEMANDED

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

PRELIMINARY STATEMENT

1. The United States brings this complaint under the False Claims Act, 31 U.S.C. §§ 3729-33, and common law, alleging that during the period from August 2001 through June 2010, Westchester County Health Care Corporation, doing business as Westchester Medical Center ("WCHCC" or "defendant"), a 600-bed hospital in Valhalla, New York, billed Medicaid for millions of dollars of outpatient services at its mental health center for which it lacked core documentation required by Medicaid regulations. *See* 14 NYCRR Parts 587, 588 and 592[1]; 18 NYCRR § 505.25; 2 C.F.R. §225, App. A(C)(1)(c). Medicaid regulations expressly require mental health outpatient clinics to maintain certain critical documents, including progress notes and treatment plans, to ensure that services are provided as billed and in compliance with applicable regulations. In addition, Medicaid regulations require that mental health outpatient clinics meet certain requirements for the duration of therapy services, including group therapy services, in order for those services to be reimbursable by the Medicaid program.

2. Although WCHCC management knew for years that WCHCC's outpatient mental health clinic was missing documentation that was required to bill for services, WCHCC failed until at least June 2010 to take any but the most insignificant steps to address the problem and to conduct any systematic audit of the clinics' records. Nor did WCHCC return funds it received from the Medicaid program despite knowing it had been substantially overpaid as a result of

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[1] On October 1, 2010, the New York State Office of Mental Health ("OMH") adopted new mental health clinic regulations, 14 NYCRR Part 599, that updated and replaced 14 NYCRR §§ 587-88, strengthening the requirements for treatment plans, progress notes and other documentation. The conduct at issue in this complaint occurred prior to the adoption of Part 599.

having billed for services for which it lacked required documentation. As a result of this billing fraud, WCHCC was paid millions of dollars by the Medicaid program to which it was not entitled.

JURISDICTION AND VENUE

3. This Court has jurisdiction over the claims brought under the False Claims Act pursuant to 31 U.S.C. § 3730(a) and 28 U.S.C. §§ 1331, 1345.

4. Venue lies in this District pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. §§ 1391(b), 1391(c), because defendant does business in this district.

PARTIES

5. Plaintiff is the United States of America on behalf of its agency the United States Department of Health and Human Services ("HHS").

6. Westchester County Health Care Corporation is a public benefit corporation established under Article 10-C of the New York Public Authorities Law, N.Y. Pub. Auth. Law §§ 3300 *et seq.*, which does business as Westchester Medical Center. Westchester Medical Center, located in Valhalla, New York, includes the largest public mental health facility in Westchester County, New York, with over 100 beds. The mental health facility, known as the Behavioral Health Center ("BHC"), operates as a hospital-based mental hygiene provider jointly licensed by the New York State Office of Mental Health ("OMH") under Article 31 of the New York State Mental Hygiene Law and by the New York State Department of Health ("DOH") under Article 28 of the New York State Public Health Law.

7. In its outpatient department ("OPD"), the BHC provides outpatient behavioral health services to children, adolescents and adults who are mentally ill or suffer from psychiatric or emotional conditions. As a provider of outpatient mental health services that is jointly

licensed by OMH and DOH, the BHC was paid a per-visit, fee-for-service rate that was determined in accordance with the applicable DOH rate-setting methodology for hospital outpatient department services. In addition, under the Comprehensive Outpatient Program Services ("COPS") program, an OMH program intended to compensate facilities for providing an "enhanced" level of services, *see* 14 NYCRR Part 592[2], the BHC received supplemental payments from Medicaid for each visit to the OPD.

FACTUAL ALLEGATIONS

A. The Medicaid Program

8. Pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, the Medicaid Program was established in 1965 as a joint federal and state program to provide financial assistance to individuals with low incomes to enable them to receive medical care. Under Medicaid, each state establishes its own eligibility standards, benefit packages, payment rates, and program administration in accordance with certain federal statutory and regulatory requirements. The state directly pays the health care providers for services rendered to Medicaid recipients, with the state obtaining the federal share of the Medicaid payment from accounts that draw on the United States Treasury. *See* 42 C.F.R. §§ 430.0-430.30.

9. The New York State Legislature established New York's Medicaid system in 1966, L. 1966, ch. 256, the year after Congress created the federally funded Medicaid program, see Pub. L. 89-97, 79 U.S. Stat. 344. Under New York's system, Medicaid is administered at the state level by DOH. See N.Y. Pub. Health Law § 201(1)(v). The State of New York, through DOH, has promulgated an extensive regulatory scheme governing the administration of the

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[2] *See also* OMH's "Comprehensive Outpatient Program Services (COPS) Level I Description," http://www.omh.ny.gov/omhweb/spguidelines/HTML/cops_level_1.html.

Medicaid program within the State.

10. Federal regulations require compliance with state rules and regulations as a condition of payment of the Federal share of Medicaid. *See* 2 C.F.R. § 225 App. A(C)(1)(c).

B. WCHCC's Reckless Indifference to Missing Documentation in the OPD

11. Despite submitting claims to Medicaid for hundreds of thousands of dollars of services annually, the OPD had virtually no compliance program prior to mid-2010 to ensure that the services took place or that they were provided in accordance with applicable regulations. Until 2010, when it was forced to confront its problems as a result of a government audit, WCHCC avoided dealing with compliance issues and focused instead on maximizing billing. Not only was WCHCC management aware that there were major problems with compliance at the OPD, but it actually took steps to avoid dealing with those problems. Meanwhile, at least during the period from January 2008 through June 2010, WCHCC routinely submitted periodic certifications to Medicaid attesting that "the services [for which it claimed payment] were furnished in accordance with applicable federal and state laws and regulation."

12. In January 2008, Cathy Ciavarello, the administrator of the OPD, conducted an audit of OPD documentation after she and her staff noted on a number of occasions that the notes written by several clinicians regarding patient visits, known as progress notes, could not be located for a number of visits that had been billed by the OPD. Based on her findings, she reported to Dominick Lepore, the vice president of the BHC and executive in charge of the OPD, that she was "deeply concerned about the billing practices in the BHC-OPD."

13. Moreover, Ms. Ciavarello noted that she had previously brought the OPD's documentation problem to the attention of the OPD's clinical director, Dr. Debbie Cross. Ms. Ciavarello wrote in a memo to Mr. Lepore that she "raised this issue to Dr. Cross on several

occasions, the last time being October 12, 2007 via email, and was told [by Dr. Cross], '[T]hat is not your concern. I'll take care of it.'"

14. However, Dr. Cross did not take care of the problem. Months after bringing it to the attention of Dr. Cross and Dr. Neil Zolkind, the clinical vice-chair for psychiatry at WCHCC and Dr. Cross's supervisor, as well as Cary Wagner, the administrator in charge of the Crisis Psychiatric Emergency Program ("CPEP") at the BHC, Ms. Ciavarello wrote to Mr. Lepore that she was "distressed to see that the problem has not been resolved." Instead, one of the clinicians with the worst record of missing documentation, whose progress notes had been missing for months, wrote notes after the fact with the approval of clinical management at the BHC. In addition, WCHCC failed to return the funds received from Medicaid for the improperly billed claims identified by Ms. Ciavarello.

15. Moreover, despite the poor results of the January 2008 audit, WCHCC did not conduct any review of its records prior to January 2008 to ascertain whether documentation was missing for the audited clinicians during any time period prior to the date of the audit. Nor did WCHCC audit any other clinicians at the OPD to determine whether the problem of missing documentation went beyond those who were included in the January 2008 audit.

16. WCHCC also failed to institute any compliance program despite Ms. Ciavarello's warning to Mr. Lepore that if the OPD were ever subject to a government audit "the results would not be favorable."

17. Instead, a month after Ms. Ciavarello discussed her audit findings with Mr. Lepore, Drs. Zolkind and Cross and Mr. Wagner, management stripped her of her responsibilities as administrator of the OPD.

18. The only documentation tracking program the OPD put in place was a system

for ensuring that OPD billed for every patient visit logged into its registration system. This system checked registrations against billing data known as "encounter forms" to maximize billing, but did not check for whether documentation such as progress notes or treatment plans was present for the visit.

19. WCHCC was finally forced to confront the OPD's documentation problems in 2010 when the Office of the Medicaid Inspector General ("OMIG") of the New York State Department of Health audited the OPD for the period from 2004 through 2007. As the OPD began looking for the documentation requested by the OMIG, including progress notes and treatment plans, it became impossible for WCHCC to continue ignoring the problems.

20. As a result of the OMIG audit, WCHCC temporarily stopped billing for services in the OPD in June 2010. Mark Fersko, WCHCC's Chief Financial Officer, sent an email to Drs. Cross and Zolkind and to Bruce Anderson, then administrative head of the BHC, stating that all mental health clinic billings had been placed on hold pending a complete pre-billing review because "material issues" had been found in the medical records that "require your immediate attention and mandate we set up a training session ASAP." Even at that time, before the full depth of the problem was known, Mr. Fersko acknowledged that "there is $2.2 million at risk in the clinic."

21. Moreover, the OPD's documentation problems were confirmed by a medical record review of the OPD conducted in mid-2010 by WCHCC's Health Information Services department, which is entirely separate from the BHC. In a report presented to WCHCC's Legal Medical Records Steering Committee, the Health Informaton Services department stated that "encounter forms [from the BHC OPD] were sent to billing without verifying that there is documentation of the service."

22. Finally, only after the OPD's problems had come under intense government scrutiny, did WCHCC begin the process of putting in place a compliance program for the OPD. Ms. Ciavarello, as the administrator at the WCHCC with the most extensive knowledge of the OPD's administrative operations, was reinstated to her position as administrator of the OPD to implement the program.

C. Regulatory Framework

23. Under regulations issued by OMH governing outpatient mental health programs, treatment planning is one of the cornerstones of the provision of services in such programs. *See, e.g.*, OMH, "Medicaid Requirements for OMH-Licensed Outpatient Programs" (January 2004) (hereinafter "Medicaid Requirements for OMH-Licensed Outpatient Programs"), at page 8. During the time period at issue in this complaint, OMH's regulations stated that "[t]reatment planning shall be an ongoing assessment process carried out by the professional staff in cooperation with the recipient and his or her family," based on "the recipient's psychiatric, physical, social and/or psychiatric rehabilitation needs," and including identification of the recipient's mental health diagnosis, the goals for the recipient's treatment, and the "specific objectives and services necessary to accomplish [those] goals." 14 NYCRR §587.16(a)-(b)[3]; *see also* §587.16(g).

24. OMH regulations provided that "[t]he treatment plan . . . shall be developed prior to the fourth visit after admission or within 30 days of admission, whichever comes first. " *Id.* at §588.6(g).

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[3] These provisions are now found in 14 NYCRR Part 599, the updated OMH regulations for mental health clinics adopted on October 1, 2010. The requirements regarding treatment plans and progress notes, among other requirements cited here, were strengthened under the new OMH regulations.

25. Furthermore, the regulations provided that treatment plans must be reviewed every three months, *id.* at §588.6(g), to reflect "changes in the recipient's condition or needs and the services and treatment provided." *Id.* at §587.16(a).

26. In addition, both a patient's initial treatment plan and its revisions had to be signed by "the physician involved in the treatment." *Id.*

27. Progress notes are also an essential part of outpatient psychiatric treatment under the OMH regulations. The regulations provided that "[p]rogress notes shall be recorded by the clinical staff member(s) who provided services to the recipient. Such notes shall identify the particular services provided and the changes in goals, objectives and services, as appropriate." *Id.* at §587.16(f). With respect to clinic treatment programs, the OMH regulations required that progress notes be recorded for "each visit and/or contact" with the recipient. *Id.*

28. Moreover, progress notes had to be completed contemporaneously with clinic visits. *See, e.g.*, Medicaid Requirements for OMH-Licensed Outpatient Programs at 10 ("Treatment/services plans and related reviews, and progress notes, when signed, should be dated so that compliance with completion schedules can be tracked.").

29. Under both OMH and DOH regulations, an outpatient psychiatric clinic could not bill Medicaid for services in the absence of a treatment plan and progress notes. 14 NYCRR §588.5 ("Reimbursement shall only be made for services identified and provided in accordance with an individual treatment plan . . . . "); 18 NYCRR §505.25(d). DOH's regulations provided that "in order to bill under [Medicaid] . . . [a]ll programs must meet the standards set forth by 14 NYCRR Parts 579 and 585, as revised on April 1, 1991, by the addition of 14 NYCRR Parts 587 and 588," which required treatment plans, including revised treatment plans, and progress notes. *Id.* at §505.25(d). The regulations further stated that "[a]ll services shall be delivered in

accordance with a valid treatment plan" and "[a]ll reimbursable billings shall only be for a documented, definable medical service of face-to-face professional exchange between provider and client . . . in accordance with goals stated in the treatment plan." *Id.* at §505.25(e)(5).

30. In addition, the regulations prescribed the amount of time that must be spent with a patient in order for a clinic visit to be reimbursable by Medicaid, depending on whether the visit is for individual or group therapy. *See* 14 NYCRR §588.6. The regulations stated that a "[b]rief visit . . . shall be reimbursed for services of at least 15 minutes in duration but not more than 29 minutes of face-to-face interaction between one recipient and one therapist." *Id.* at § 588.6(a)(1). A "[r]egular visit . . . shall be reimbursed for services of at least 30 minutes in duration of face-to-face interaction between one recipient and one therapist." *Id.* at §588.6(a)(2). A "[c]risis visit . . . shall be reimbursed for services of at least 30 minutes in duration of face-to-face interaction between one recipient and one therapist." *Id.* at §588.6(a)(3). A "[g]roup therapy visit[] . . . shall be reimbursed for services of at least 60 minutes duration provided to from 2 to 12 recipients and a therapist(s)." *Id.* at §588.6(a)(4).

D. The Documentation Problems in the OPD

31. Despite these clear rules, WCHCC repeatedly billed Medicaid for services despite the absence of a valid treatment plan and/or progress notes. For example, WCHCC billed for over a dozen visits for patient P.R.#1, a 48-year old woman with a diagnosis of bipolar disorder, depression and borderline personality disorder, with numerous chronic physical illnesses, during an almost six month period, from November 15, 2006, through April 30, 2007, even though no treatment plan was in place for the patient during that time period. On April 30, 2007, a purported treatment plan was entered on the patient's electronic medical records chart with a notation that it was completed "on 4/20/07 for 11/15/06." It was not signed by the

clinician who prepared it until April 30, 2007, or by the attending physician until May 1, 2007. An attestation signed by the patient P.R.#1 indicated that the treatment plan was not reviewed with her until May 1, 2007. Moreover, the plan identified March 15, 2007, as the target date for achievement of the plan's objectives even though that date had already passed when the goals and objectives were actually written.

32. On the same date that the treatment plan was entered into the chart, April 30, 2007, a purported treatment plan review for patient P.R.#1 was also written and marked with a notation that it was completed "on 4/20/07 for 3/15/07." Like the treatment plan that was purportedly "for 11/15/06," the treatment plan review that was purportedly "for 3/15/07" was signed by the clinician on April 30, 2007, and by the attending physician on May 1, 2007. Similarly, the patient was shown both the treatment plan and the treatment plan review on the same date, May 1, 2007, even though the treatment plan review should have been a review of her progress toward the goals and objectives of a date that had already passed.

33. WCHCC also billed Medicaid for dozens of purported services to patient H.B., an adolescent with a diagnosis of attention deficit hyperactivity disorder, learning disorders and mild mental retardation, in 2007 even though there was no review of the patient's treatment plan at any time after June 2006. Further, there is no documentation whatsoever with respect to many of the patient's visits; in 2007 alone, WCHCC submitted over 16 bills for which there were no progress notes documenting what occurred at the purported visits. Even where progress notes were completed, they were often dated months after the date of the purported visit.

34. WCHCC also submitted a claim for purported psychotherapy on May 24, 2004, for a patient A.P., a 73 year-old woman with schizoaffective disorder, a serious mental illness, even though there was no documentation of any treatment plan having been done for this patient

and no progress note documenting the purported visit. The only record of the patient's visit to the clinic was a physician's order sheet with notes regarding the patient's medications. The order sheet does not even indicate that the patient was seen in person but only that the patient was written a prescription on May 24, 2004, which could have been done over the phone. The medication order indicates that the patient's dosage of Risperdal, an antipsychotic medication, was decreased, and her prescription for amatidine, another psychotropic medication, was discontinued, without any record of the reasons for these changes in the patient's treatment.

35. In addition to missing treatment plans and missing progress notes, WCHCC also billed in instances where purported therapy sessions failed to meet minimum duration requirements. For instance, progress notes with respect to group therapy visits that A.B. purportedly attended reflect that sessions were only 50 minutes, even though the regulations required that they last at least 60 minutes. *See* 14 NYCRR §588.6(a)(4). Similarly, with respect to patient P.R.#2, a 14-year old with a diagnosis of attention deficit hyperactivity disorder, WCHCC routinely billed for group sessions of a 40 or 45-minute duration.

36. In some instances, WCHCC billed for a group visit even where the patient was late or spent part of the time out of the room in which the therapy was purportedly provided. With respect to patient A.B., for instance, WCHCC billed for a group session on May 15, 2007, even though the clinician's progress notes reflect that A.B. left the group for 30 minutes of the session. WCHCC also billed for a group session on April 12, 2007, even though the progress notes reflect that A.B. arrived 45 minutes late.

37. WCHCC's billing for patients who arrived late to therapy sessions was confirmed by a nurse practioner who worked in the BHC OPD from 2008 to 2010. As further evidence of the lack of controls at BHC, this nurse practioner, who was certified in family health

and not psychiatry, worked in the BHC for two years providing psychiatric services even though she lacked credentials by WCHCC to work at the BHC, and even though the New York State Education Department prohibits nurse practicioners who are not certified in psychiatry from providing psychiatric services.

38. WCHCC also submitted bills to Medicaid even where the purported group therapy visit was for "music therapy," a treatment not covered by Medicaid. *See* 18 NYCRR § 505.25(b). For instance, with respect to patient T.S., a 27-year old man with paranoid schizophrenia, WCHCC billed Medicaid at least six times in a five month time frame for "music therapy/group therapy." Some of the notes indicated that group members played piano and percussion instruments as part of the sessions, and several of the sessions included yoga and stretching exercises, rather than the talk therapy that was reimbursable under the Medicaid regulations.

FIRST CLAIM

Violations of the False Claims Act: Presentation of False Claims (31 U.S.C. § 3729(a)(1) (2008))

39. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

40. The United States seeks relief against defendant under Section 3729(a)(1) of the False Claims Act, 31 U.S.C. § 3729(a)(1)(2008).

41. As set forth above, in connection with the foregoing schemes, defendant knowingly, or with reckless disregard for the truth, presented and/or caused to be presented false or fraudulent claims for payment to federal agencies and/or entities that were receipients of federal funds.

42. By reason of these false claims, the United States has sustained damages in a

substantial amount to be determined at trial, and is entitled to a civil penalty as requird by law for each violation.

SECOND CLAIM

Violations of the False Claims Act: Making or Using a False Record or Statement (31 U.S.C. § 3729(a)(1)(A))(2010))

43. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

44. The United States seeks relief against defendant under Section 3729(a)(1)(A) of the False Claims Act, 31 U.S.C. § 3729(a)(1)(A) (2010).

45. As set forth above, in connection with the foregoing schemes, defendant knowingly, or in reckless disregard for the truth, presented and/or caused to be presented false or fraudulent claims for payment to federal agencies and/or entities that were receipients of federal funds.

46. By reason of these false claims, the United States has sustained damages in a substantial amount to be determined at trial, and is entitled to a civil penalty as requird by law for each violation.

THIRD CLAIM

Violations of the False Claims Act: Making or Using a False Record or Statement (31 U.S.C. § 3729(a)(1)(B))(2010))

47. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

48. The United States seeks relief against defendant under Section 3729(a)(1)(B) of the False Claims Act, 31 U.S.C. § 3729(a)(1)(B)(2010).

49. As set forth above, in connection with the foregoing schemes, defendant

knowingly, or in reckless disregard for the truth, made, used, and caused to be made and used false records and statements material to false or fradulent claims.

50. By reason of these false claims, the United States has sustained damages in a substantial amount to be determined at trial, and is entitled to a civil penalty as requird by law for each violation.

FOURTH CLAIM

Reverse False Claims
(31 U.S.C. § 3729(a)(7)(2008))

51. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

52. The United States seeks relief against defendant under Section 3729(a)(7) of the False Claims Act, 31 U.S.C. § 3729(a)(7)(2008).

53. As set forth above, in connection with the foregoing schemes, defendant knowingly, or with reckless disregard for the truth, made, used and/or caused to be made or used a false record or statement to conceal or avoid or decrease an obligation to pay or transmit money or property to the Medicaid program.

54. WCHCC was under an obligation to return Medicaid overpayments.

55. By reason of these false claims, the United States has sustained damages in a substantial amount to be determined at trial, and is entitled to a civil penalty as requird by law for each violation.

FIFTH CLAIM

Reverse False Claims
(31 U.S.C. § 3729(a)(1)(G)(2010))

56. The United States incorporates by reference each of the preceding paragraphs as

if fully set forth in this paragraph.

57. Section 6402(a) of the Patient Protection and Affordable Care Act ("ACA"), passed March 1, 2010, requires providers to report and return overpayments of Medicaid funds within 60 days after the overpayment is identified. H.R. 3590, 11th Cong. § 6402(a) (2010). An "overpayment" is defined in the statute as "any funds that a person receives or retains under [Medicaid] to which the person . . . is not entitled under such title." *Id.* The ACA also makes it a violation of the FCA, as a "reverse false claim," to fail to return the overpayment. *Id.*

58. Although WCHCC was aware of extensive documentation issues, not only did it fail to take prospective action to stem the submission of fraudulent bills, it also failed to make refunds of Medicaid payments to the Medicaid program related to improper billing at the OPD. The only refund offered by WCHCC, in the amount of $121,052.57 in December 2011, was entirely inadequate and untimely.

59. By reason of the foregoing, the United States was damaged in a substantial amount to be determined at trial.

SIXTH CLAIM

Payment Under Mistake of Fact

60. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

61. The United States seeks relief against WCHCC to recover monies paid under mistake of fact.

62. The United States made payments under the Medicaid program for services rendered under the erroneous belief that WCHCC was entitled to payment of such funds. In

making such payments, the United States relied upon and assumed WCHCC had complied with applicable Medicaid rules and regulations and that the claims for Medicaid reimbursement were consistent with the relevant Medicaid regulations. This erroneous belief was material to the United States' decision to pay these claims. In such circumstances, the United States' payment of federal funds under the Medicaid program was by mistake and was not authorized.

63. By reason of the foregoing, the United States was damaged in a substantial amount to be determined at trial.

SEVENTH CLAIM

Unjust Enrichment

64. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

65. The United States seeks relief against WCHCC to recover monies paid under mistake of fact.

66. The United States made payments under the Medicaid program for services rendered under the erroneous belief that WCHCC was entitled to payment of such funds. By reason of such payments, WCHCC was unjustly enriched. The circumstances of WCHCC's receipt of these payments are such that, in equity and good conscience, WCHCC should not retain these payments, the amount of which is to be determined at trial.

EIGHTH CLAIM

Negligence

67. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

68. The United States seeks relief against WCHCC to recover monies paid because

of WCHCC's negligence.

69. WCHCC was negligent in failing to comply with regulations relating to filing claims for reimbursement from Medicaid for services purportedly provided at its outpatient mental health clinics. The United States made substantial Medicaid payments that would not have been made but for WCHCC's representation that the purported services were provided in complaince with Medicaid regulations requiring that treatment plans and progress notes be maintained for the patients.

70. By reason of the foregoing, the United States was damaged in a substantial amount to be determined at trial.

WHEREFORE, plaintiff, the United States, requests that judgment be entered in its favor and against defendant for treble the United States' damages, in an amount to be determined at trial, plus civil penalties for each false claim presented, and any other relief as is proper.

Dated: New York, New York
October 23, 2012

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United States of America

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