IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA, *ex rel.* GERALD P. ASTORINO Plaintiff, v. JOSEPH R. MERMELSTEIN, M.D. Defendant.	FILED UNDER SEAL As required by 31 U.S.C. § 3730 (b)(2) Civ. Action No. **COMPLAINT AND** **DEMAND FOR JURY TRIAL**

OVERVIEW OF COMPLAINT

1. This is a civil action brought by relator Gerald P. Astorino ("Astorino" and/or "Relator") on his own behalf and on behalf of the United States of America ("United States") against defendant Joseph R. Mermelstein, M.D. ("Mermelstein"), under the *qui tam* provisions of the Civil False Claims Act, 31 U.S.C. § 3729, *et seq*. (the "False Claims Act" or "FCA"), to recover damages, civil penalties, and other relief owed to the United States and Astorino.

2. In connection with the receipt of reimbursement from the United States Department of Health and Human Services ("HHS"), Centers for Medicare and Medicaid Services ("CMS"), Defendant committed fraud against the Medicare Program, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395ccc and 42 C.F.R. Parts 400-1004, by (a) knowingly presenting, and causing to be presented to an officer and employee of the United States Government false and fraudulent claims for payment and approval; and (b) knowingly making, using, and causing to be made and used, false

records and statements to get false and fraudulent claims paid and approved by the Government, in violation of 31 U.S.C. §§ 3729(a)(1) and (2).

3. In brief, Defendant, a practicing ophthalmologist whose office is located on Staten Island, defrauded CMS by billing for eye health care services that were not performed at all ("phantom services"), by billing at for services reimbursable at a higher rate than the services actually performed ("upcoding") and by billing for services that were provided in a substandard manner ("substandard care").

JURISDICTION AND VENUE

4. This Court has subject matter jurisdiction over the claims alleged in this Complaint under 28 U.S.C. §§ 1331 (Federal question), 1345 (United States as plaintiff) and 31 U.S.C. § 3732(a) (False Claims Act).

5. This Court has personal jurisdiction over the Defendant named in the Complaint pursuant to 31 U.S.C. § 3732(a) because the Defendant can be found, resides, and transacts business in the Eastern District of New York and because an act proscribed by 31 U.S.C. § 3729 occurred within this District. Title 31, United States Code, Section 3732(a) further provides for nationwide service of process.

6. Upon information and belief, there are no pending actions that would be deemed to be related to this action, and further, this Complaint is not based on the facts underlying any such pending action, within the meaning of the False Claims Act's first to file rule, 31 U.S.C. § 3730(b)(5).

7. This action is not precluded by any provisions of the False Claims Act's jurisdiction bar, 31 U.S.C. § 3730(e) *et seq*. This action is not brought by a current or former member of the armed services against another member of the armed services

arising out of such person's service in the armed forces. 31 U.S.C. §3730(e)(1). Nor, is it brought against a member of Congress, the judiciary or a senior executive branch official and based upon evidence or information already known to the Government. 31 U.S.C. §3730(e)(2).

8. Upon information and belief, this Complaint is not based upon allegations or transactions that are the subject of a civil suit or an administrative civil money penalty proceeding in which the United States is already a party. 31 U.S.C. §3730(e)(3).

9. Upon further information and belief, there has been no "public disclosure" of the matters alleged herein and this action is not "based upon" any such disclosure, within the meaning of 31 U.S.C. §3730(e)(4)(A). Notwithstanding the foregoing, through his first-hand dealings with Defendant, Astorino has "direct and independent knowledge" of the instant allegations. Additionally, Astorino has "voluntarily provided," and offered to provide, this information to the Government before filing this Complaint. Therefore, to the extent any of these allegations is deemed to have been based upon a public disclosure, Astorino is an "original source" of this information as defined by 31 U.S.C. §3730(e)(4)(B) of the False Claims Act, and as such, he is expressly excepted from its public disclosure bar.

10. Venue is proper in the Eastern District of New York, under 28 U.S.C. §§ 1391(b) and (c), and 31 U.S.C. § 3732(a), because (a) the Defendant resides in this District, (b) a substantial part of the events or omissions giving rise to the violations of 31 U.S.C. § 3729 alleged in the Complaint occurred in this District, and (c) because Defendant can be found in and transacts business within this District.

PARTIES

11. The United States, through the HHS/CMS, is the real plaintiff party in interest in this action. The headquarter offices for HHS are located at 200 Independence Avenue, S.W., Washington, D.C. 20201, and the main offices for CMS are located at 7500 Security Boulevard, Baltimore, MD 21244-1850.

12. Relator Astorino resides in Staten Island, New York. He is an optometrist licensed by the State of New York. Beginning on or about June 24, 2002, Astorino began working as an optometrist for Defendant on an intermittent fill-in basis and later he worked regularly for Defendant three days per week (M,W, F). In or about April 2003, Defendant fired Astorino without any notice. Upon information and belief, Astorino was terminated because he attempted to provide proper medical services to Defendant's patients and Defendant resented Astorino's active involvement in the patients' health care.

13. Defendant Mermelstein provides eye care health services from an office located at 2177 Victory Boulevard, Staten Island, New York, 10314. Upon information and belief, Defendant is a licensed and board certified ophthalmologist. He provides eye care health services to, among other patients, elderly persons who are beneficiaries under the Medicare Program, Part B.

14. Upon information and belief, Empire Medicare Services ("Empire") is the local Medicare carrier that, under contract with CMS, receives and processes Defendant's claims for Medicare reimbursement under Part B of the Medicare Program. Empire's principal office is located at 2651 Strang Boulevard, Yorktown Heights, New York, 10598.

THE FALSE CLAIMS ACT

15. The False Claims Act ("FCA") provides, in pertinent part, that:

> (a) Any person who…(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government…a false or fraudulent claim for payment or approval; [and] (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; …
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> is liable to the United States Government for a civil penalty of not less than $[5,500] and not more than $[11,000], plus 3 times the amount of damages which the Government sustains because of the act of that person….
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> (b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information…(1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729.

THE MEDICARE PROGRAM

16. At all times relevant to this Complaint, the Medicare Program, see Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395ccc and 42 C.F.R. Parts 400-1004, was a federally funded and administered program intended to assist elderly persons (and others) in paying for the cost of health care. The Medicare program works by reimbursing health care providers for the cost of services and ancillary items at determined rates. Reimbursements are made out of the Medicare Trust Fund.

17. The Medicare Trust Fund is supposed to reimburse health care providers, such as Defendant, at established rates and only for those services that are

actually performed and are medically necessary for the health of the patient and that are ordered specifically by a physician, using appropriate medical judgment and acting in the best interest of the patient. The Medicare Trust Fund relies on the implied representations of the suppliers of Medicare services, reimbursable in whole or in part under Medicare that the services billed by the providers were medically necessary for the patient and were actually performed as billed and compensable by Medicare. Medicare requires that the service had to be physically performed and billed according to Medicare policies and procedure codes. Medicare services provided by physicians in their offices are typically deemed to be under Part B of the Medicare Program.

18. The Centers for Medicare and Medicaid Services (CMS) are the part of the U.S. Department of Health and Human Services that oversees the Medicare Program. For the purpose of administering Part B Medicare reimbursement claims CMS contracts with local insurance carries. These insurers are known as Local Medicare Carriers.

19. Empire Medicare Services (Empire) is the Local Medicare Carrier responsible for Medicare Part B billing for physicians located on Staten Island, New York.

SPECIFIC FACTUAL ALLEGATIONS

20. At all times relevant to this Complaint, Defendant treated many elderly patients and sought reimbursements from the Medicare Program. In recent years, Defendant has submitted reimbursement claims to the Medicare Program through electronic billing. Many of the claims he has submitted are false and fraudulent because they are for phantom services, upcoded services or substandard care.

21. For example, Defendant has routinely submitted false invoices to the Medicare Program for performing punctal occlusion procedures (CPT Code 68761). This procedure involves putting plugs in the eyelids to address tearing and dry eye syndromes (ICD-9 Code 375.15). Defendant regularly bills for the implantation of plugs when none have been put in; bills for more expensive permanent (silicone) plugs when only temporary (collagen) ones have been put in; and bills for four plugs (upper and lower lids in both eyes) when only two plugs have been put in.

22. Defendant routinely performs punctal occlusions without administering the proper diagnostic tests.

23. Defendant regularly performs cataract surgery and provides inadequate post-op care.

24. Defendant regularly purports to perform a test to determine if the patient is suffering from red eye (CPT Code 68100) and bills for this, when in fact he fakes doing the test and does not obtain any result.

25. Defendant regularly receives referrals of patients with a possible Glaucoma diagnosis (ICD-9 Code 365.1). He is suppose to perform appropriate diagnostic tests to evaluate the patients and is permitted to bill the Medicare Program for tests that were actually done. In many instances, however, Defendant bills the Medicare Program for Glaucoma diagnostic tests that are never performed, including, Gonioscopies (CPT Code 92020).

26. In other instances Defendant does not perform routine tests that are called for in evaluating Glaucoma patients, including Dilated Fundus Evaluations and Tonometry, but falsely notes in patient charts that such tests have been done.

27. Additionally, Defendant does not actually interpret the results of Glaucoma diagnostic tests which had in fact been performed by technicians or Optometrists at his facility, including Visual Field Tests (CPT Code 92083) and Laser Disc Scans (CPT Code 92135). Nor, does Defendant discuss the results of such tests with the patients, as is required under general standards of care.

28. During one period, Defendant was administering and billing an ERG/VEP spectrometry test that yielded completely meaningless results. Yet, Defendant billed the Medicare Program for this service.

29. Defendant regularly has an optometrist or technician perform an endo cell count to avoid cataract surgery complications, but Defendant never uses the results of these tests, and in fact does not know how to interpret them.

30. In order to justify billing the Medicare Program for "Routine Eye Exams," Defendant regularly notes false diagnoses in patient charts (for example, under ICD-9 Codes 379.24, 373.00 and 375.15), when in fact no disease is present.

31. Defendant regularly bills the Medicare Program for office visits by falsely overstating the amount of time actually spent with patients. The is done by using higher prefixes (numbered 1 [least time] through 5 [most time]) on the so-called "E&M Code" for office visits (CPT Code 9921_) than is warranted by the actual time spent with the patients.

32. Defendant regularly sees an excessive number of patients per day (approximately 60) and therefore cannot provide adequate services to them all.

33. Defendant regularly uses improper test procedures for Laser Treatment purposes. He subjects patients to Fluorescein Angiography Tests (CPT Code

92235) without first performing the required Dilated Fundus Evaluation. Additionally, he sends the Fluorescein Angiography Tests to an outside source for interpretation and Defendant relies on that entity's conclusions without independently verifying them. After that, in approximately 80% of such cases, Defendant performs and bills the Medicare Program for Focal Retinal Laser (CPT Code 67201) or PRP Retinal Laser (CPT Code 67228) without regard to the patients' actual condition, thereby increasing the risk of Decreased Visual Function.

34. Defendant has regularly provided substandard medical care to his patients, including, but not limited, by the following practices:

a. Not dilating patients' pupils (with pharmaceuticals) before and after Cataract Surgery to determine if any other preexisting conditions are present and whether any complications occurred during surgery.

b. Not taking and/or not recording true and accurate Intra-ocular "pressures" to determine whether or not medications prescribed for Glaucoma patients are efficacious.

c. Not administering preliminary tests (such as first visit pupil dilations) before performing other procedures (such as an Angiogram for Glaucoma). And,

d. Causing patients to undergo unnecessary health care procedures, such as VEPs, ERGs, Focal Lasers and PRP Lasers.

35. Defendant has regularly been named in numerous malpractice claims and complaints.

36. Upon information and belief, Defendant and knew of the proper policies, procedures and criteria for obtaining reimbursements under the Medicare

Program. He knowingly violated such policies, procedures and criteria in order to fraudulently obtain greater reimbursement payments than he was entitled to receive.

37. Evidence of Defendants' knowing conduct includes his creation of duplicate patient charts with false information when he has been required to produce backup documentation to CMS, private insurers and litigants.

38. As set forth above, Defendant knowingly submitted or caused to be submitted untruthful, incorrect or incomplete requests for payment to Medicare, in violation of 31 U.S.C. § 3729.

39. As a result of Defendant's unlawful conduct the United States reimbursed Defendant for greater amounts than he was otherwise entitled to receive.

40. Upon information and belief, Defendant has been claiming reimbursement under the Medicare Program since before February 1998 through the filing of this Complaint. And upon further information and belief, he has submitted false and fraudulent claims to the Medicare Program from at least in or about February 1998 through the filing of this Complaint.

41. Relator and the United States did not know, and could not reasonably have known, before 1998, of the facts material to the causes of action pled in this Complaint.

FIRST CAUSE OF ACTION
FALSE CLAIMS ACT VIOLATIONS
(31 U.S.C. §§ 3729(a)(1) and (2))

42. The allegations contained in paragraphs 1 through 41, above, are realleged as if fully set forth below.

43. Between in or about February 1998 through in or about the filing of this Complaint, Defendant knowingly (a) presented, and caused to be presented to an officer and employee of the CMS, through Empire, requests for payment; and (b) knowingly made, used, and caused to be made and used, false records and statements, all in violation of 31 U.S.C. §§ 3729(a)(1) and (2).

44. Upon information and belief, had CMS known the true facts underlying Defendant's fraudulent claims for reimbursement it would not have caused the United States to pay Defendant the amounts requested.

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

PRAYER FOR RELIEF

WHEREFORE, Relator Astorino, on behalf of himself individually, and acting on behalf, and in the name, of the Government of the United States, respectively, demands and prays that judgment be entered against the Defendant as follows:

1. That Defendant be ordered to cease and desist from violating the False Claims Act, 31 U.S.C. § 3729 *et seq*.

2. On the First Cause of Action under False Claims Provisions of the False Claims Act, Section 3729(a), judgment against Defendant in the amount of three times the amount of damages the United States has sustained because of Defendant's actions, which amount is to be determined at trial or by the court, plus a civil penalty of between $5,500 and $11,000.00 for each act in violation of the False Claims Act, as provided by Section 3729(a), with interest.

3. As further relief under the First Cause of Action, that Relator Astorino be awarded an amount available under the Qui Tam Provisions of the False Claims Act, Section 3730(d), for bringing this action, namely, between 15 and 25 percent of the proceeds of the action or settlement of the claim if the Government intervenes in the matter (or pursues its claim through any alternate remedy available to the Government, Section 3730(c)(5)), or, alternatively, between 25 and 30 percent of the proceeds of the action or settlement of the claim, if the Government declines to intervene.

4. Further, that Relator Astorino be awarded all reasonable expenses that were necessarily incurred in prosecuting this action, plus all reasonable attorneys' fees and costs, as provided by Section 3730(d).

5. And further, that Relator Astorino be awarded prejudgment interest.

6. And finally, that the United States and Relator Astorino be awarded such other relief in law or equity as this Court deems just and proper

DEMAND FOR JURY TRIAL

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Relator Astorino hereby demands trial by jury.

Respectfully submitted,

/s/timothy j mcinnis

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