UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF GEORGIA
SAVANNAH DIVISION

UNITED STATES OF AMERICA, *Ex. Rel.* SHEILA McCRAY;

STATE OF GEORGIA, *Ex. Rel.* SHEILA McCRAY;

STATE OF CALIFORNIA, *Ex. Rel.* SHEILA McCRAY;

STATE OF COLORADO, *Ex. Rel.* SHEILA McCRAY;

STATE OF CONNECTICUT *Ex. Rel.* SHEILA McCRAY;

STATE OF FLORIDA, *Ex. Rel.* SHEILA McCRAY;

STATE OF ILLINOIS, *Ex. Rel.* SHEILA McCRAY;

STATE OF LOUISIANA, *Ex. Rel.* SHEILA McCRAY;

STATE OF MASSACHUSETTS, *Ex. Rel.* SHEILA McCRAY;

STATE OF NEW JERSEY, *Ex. Rel.* SHEILA McCRAY;

STATE OF NEW YORK, *Ex. Rel.* SHEILA McCRAY;

STATE OF NORTH CAROLINA, *Ex. Rel.* SHEILA McCRAY;

Civil Action No. CV413-127

FILED *IN CAMERA* AND UNDER SEAL

FIRST AMENDED COMPLAINT FOR VIOLATION OF FEDERAL FALSE CLAIMS ACT, 31 U.S.C. § 3729 *et seq.*

JURY TRIAL DEMANDED

STATE OF TEXAS, *Ex. Rel.* SHEILA McCRAY;	)
STATE OF VIRGINIA, *Ex. Rel.* SHEILA McCRAY;	)
STATE OF WASHINGTON, *Ex. Rel.* SHEILA McCRAY;	)
Plaintiffs –Relator(s),	)
v.	)
PEDIATRIC SERVICES OF AMERICA, INC., A DELAWARE CORPORATION, PEDIATRIC SERVICES OF AMERICA, A GEORGIA CORPORATION, PEDIATRIC HEALTHCARE, INC., PEDIATRIC HOME NURSING SERVICES, COLLECTIVELY d/b/a PSA HEALTHCARE, and PORTFOLIO LOGIC, LLC,	)
Defendants.	)

FILED IN CAMERA AND UNDER SEAL

COMES NOW Plaintiff, United States of America *ex rel.* Sheila McCray, by and through undersigned counsel, and, prior to the filing of any responsive pleading herein, amends and restates its Complaint against Pediatric Services of America, Inc., (Delaware), Pediatric Services of America, Inc. (Georgia) and Pediatric

Healthcare, Inc. d/b/a PSA Healthcare (hereinafter "PSA"), previously filed under seal herein on May 24, 2013, as follows:

I. INTRODUCTION

1. This is an action to recover damages and civil penalties on behalf of the United States of America, the States of Georgia, California, Colorado, Connecticut, Florida, Illinois, Louisiana, Massachusetts, New Jersey, New York, North Carolina, Texas, Virginia and Washington arising from various false and fraudulent statements, records, and claims made and caused to be made by the Defendants and/or their agents and employees including, but not limited to, non-reporting and underreporting payments by primary co-payments to obtain higher reimbursements, upcoding of charges for home healthcare, systematic failure to collect and writing off unpaid small co-payments and deductibles in an illegal kickback scheme in violation of, among other things the Federal Anti-Kickback Statute (42 U.S.C. § 1320-7b(b), and withholding of overpayments, all of the foregoing, in violation of Federal False Claims Act, 31 U.S.C. § 3279 *et seq.* ("the FCA" or "the Act"), the Georgia False Medicaid Claims Act (Georgia Code § 49-4-168.1, *et seq.*), the California False Claims Act (Gov. Code § 12650, *et seq.*), the Colorado Medicaid False Claims Act (Colo. Rev. State. 25.5-4-303.5, *et seq.*), the Connecticut False Claims Act for Medicaid Assistance Programs (Conn. Gen. Stat. § 17b-301(a), *et seq.*), the Florida False Claims Act (Fla. Stat. Ann § 68.081, *et*

seq.), the Illinois Whistleblower Reward and Protection Act (740 ILCS 175/1, *et seq.*), the Louisiana Medical Assistance Programs Integrity Law (LSA R.S. 46.437.1, *et seq.*), the Massachusetts False Claims Act (Mass. Gen. Laws § 5A, *et seq.*), the New Jersey False Claims Act (NJ ST. 2A:32C-1, *et seq.*), the New York False Claims Act (NY STATE FIN § 187, *et seq.*), the North Carolina False Claims Act, Code Section N.C.G.S.A. § 108A-70-10, *et seq.*), Texas Medicaid Fraud Prevention Act (TEX. HUM. RES. Code § 36.001, *et seq.*), Tex. Gov't Code Ann. § 531.101, *et seq.*, Virginia Fraud Against Taxpayers Act (VA CODE § 8.01 – 216.3).and Washington State Medicaid Fraud False Claims Act (RCW 77.66.005, *et seq.*) (collectively, the "State Acts"), and

2. The *qui tam* case is brought against Defendants for knowingly defrauding and conspiring to defraud, the federal Government and various states, including but not limited to Georgia, California, Colorado, Connecticut, Florida, Illinois, Louisiana, Massachusetts, New Jersey, New York, North Carolina, Texas, Virginia and Washington in connection with the Medicare, Medicaid and other federal health care programs.

3. PSA is the leading provider of home healthcare and related services for mentally fragile and chronically ill infants and children and is the nation's largest focused pediatric home healthcare provider. PSA has well over 50 branch offices, including satellite offices and new branch offices, located in at least 17

states[1] through at least two reportable segments (i) Pediatric and Adult Private Duty Nursing ("PDM") and (ii) Prescribed Pediatric Extended Care ("PPEC"). According to its website www.psahealthcare.com, (4/27/2013) PSA has office locations in Atlanta, Columbus, Augusta, Macon and Savannah.

4. Based on information published on its bulletin board at its Peachtree Corners Office, PSA collects between $5-6 million per week (over $300 million annually). PSA was a public company registered with the U.S. Securities & Exchange Commission and traded on the NASDAQ stock market (NASDAQ PSAI) until it was acquired in 2007 for approximately $111 million in a going private transaction by Portfolio Logic LLC and its controlled subsidiary, Pointer Acquisition Co., Inc.

5. The Relator, Sheila McCray, was initially employed as a billings specialist (until April 2012) with the title of "Accounts Receivable Specialist" in charge of "Credits"). With over 16 years as a billings specialist, Relator was hired in August 2011 by PSA to work with a reimbursement manager on clearing up "credits" and issuing refunds to payers such as private insurers, Medicare, Medicaid, Champus and other providers.

6. The FCA was originally enacted in 1863, and was substantially amended in 1986 by the False Claims Amendments Act, Pub.L. 99-562, 100 Stat.

1 California, Colorado, Connecticut, Florida, Georgia, Illinois, Louisiana, Massachusetts, New Jersey, New York, North Carolina, Oregon, Pennsylvania, South Carolina, Texas, Virginia and Washington.

3153. Congress enacted the 1986 amendments to enhance and modernize the Government's tools for recovering losses sustained by frauds against it after finding that the federal program fraud was pervasive. The amendments were intended to create incentives for individuals with knowledge of Government frauds to disclose the information without fear of reprisals or Government inaction, and to encourage the private bar to commit resources to prosecuting fraud on the Government's behalf.

7. The amended Act provides that any person who presents, or causes to be presented, false or fraudulent claims for payment or approval to the United States Government, or knowingly makes, uses, or causes to be made or used false records and statements to induce the Government to pay or approve false and fraudulent claims, is liable for a civil penalty ranging from $5,500 up to $11,000 for each such claim, plus three times the amount of the damages sustained by the federal Government.

8. The Act allows any person having information about false or fraudulent claims to bring an action for himself and the Government, and to share in any recovery. The Act requires that the complaint be filed under seal for a minimum of 60 days (without service on the defendant during that time).

9. The FCA was recently amended again by the Fraud Enforcement and Recovery Act of 2009, ("FERA"), Public Law 111-21, which President Obama

signed into law on May 20, 2009. FERA further expanded the scope of the FCA to ensure that the government can recover taxpayer dollars purportedly lost to fraud and abuse. FERA expanded the FCA, with the intent to eliminate many defense arguments, and to reverse a Supreme Court decision regarding subcontractors. *See* S. Rep. 111-10, 11th Cong.1st Sess. 10-13 (March 23, 2009).

10. FERA now makes it illegal to knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the Government. An "obligation" is now defined to include, "the retention of an overpayment." 31 U.S.C. § 3729(b)(3). Under the FCA, an act of "concealment" can also be a felony. In addition, the duty to disclose provisions of the 1977 amendments to the Social Security Act 42 U.S.C. § 1320a-7(b)(a)(3) makes concealing from the Government or failing to report Medicare overpayments a felony. Under the "duty to disclose provision" Healthcare providers and others who conceal or fail to disclose that they have received larger payments than they are entitled to be guilty of a felony and could be imprisoned for up to five years and fined up to $25,000. Their employees, including auditors, who conceal these overpayments, may also be guilty of at least a misdemeanor and subjected to fines.

11. On March 23, 2010, the Patient Protection and Affordable Care Act (Pub. L. 111-148) was enacted. The Health Care Education Reconciliation Act of 2010 (Pub. L. 111-152) then amended certain provisions of Public Law 111-148.

These public laws are collectively known as the Affordable Care Act. The Affordable Care Act makes a number of changes to the Medicare program that enhance the Government's efforts to recover overpayments and combat fraud, waste and abuse in the Medicare program.

12. Section 6402(a) of the Affordable Care Act established a new section 1128J(d) of the Act entitled "Reporting and Returning of Overpayments." Section 1128J(d)(1) of the Act requires a person who has received an overpayment to report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address, and to notify the Secretary, State, intermediary, carrier or contractor to whom the overpayment was returned in writing of the reason for the overpayment. Section 1128J(d)(2) of the Act requires that an overpayment be reported and returned by the later of— (1) the date which is 60 days after the date on which the overpayment was identified; or (2) the date any corresponding cost report is due, if applicable. Section 1128J(d)(3) of the Act specifies that any overpayment retained by a person after the deadline for reporting and returning an overpayment is an obligation (as defined in 31 U.S.C. 3729(b)(3)) for purposes of 31 U.S.C. 3729.

13. Section 1128J(d)(4)(A) defines "knowing" and "knowingly" as those terms are defined in 31 U.S.C. 3729(b); the terms "knowing" and "knowingly" "mean that a person with respect to information—(i) has actual knowledge of the

information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information." There need not be "proof of specific intent to defraud." Section 1128J(d)(4)(B) of the Act defines the term "overpayment" as any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title. Finally, section 1128J(d)(4)(C) of the Act defines the term "person" as a provider of services, supplier, Medicaid managed care organization (MCO) (as defined in section 1903(m)(1)(A) of the Act), Medicare Advantage organization (MAO) (as defined in section 1859(a)(1) of the Act) or PDP sponsor (PDP) (as defined in section 1860D-41(a)(13) of the Act) but the definition does not include a beneficiary. [See *Federal Register* Vol. 77 No. 32, February 16, 2012]. Violations, among other things, of Section 6402(a), of the Affordable Care Act are *per se* violations of the False Claims Act.

14. The Centers for Medicare & Medicaid Services ("CMS") (f/k/a the Health Care Financing Administration ("HCFA")) has also taken steps in the government's comprehensive efforts to identify improper Medicare payments, fight fraud, waste and abuse in the Medicare program. In February 2012, pursuant to the Affordable Care Act, CMS proposed that overpayments must be reported and returned if the overpayment is identified within 10 years of the date the

overpayment was received. As described in the proposed rules, CMS selected the 10 year look back period because, among other things, "this is the outer limits of the False Claims Act Statute of limitations [See *Federal Register* Vol. 77 No. 32, February 16, 2012 at page 6].

15. In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national RAC program to be in place by January 1, 2010. The national RAC program is the outgrowth of a successful demonstration program that used RACs to identify Medicare overpayments and underpayments to health care providers and suppliers. The demonstration resulted in over $900 million in overpayments being returned to the Medicare Trust Fund between 2005 and 2008 and nearly $38 million in underpayments returned to health care providers.

16. The goal of the recovery audit program is to identify improper payments made on claims of health care services to Medicare beneficiaries. Improper payments may be overpayments or underpayments. Overpayments can occur when healthcare providers submit claims that do not meet Medicare's coding or medical necessity policies.

17. As will be set forth below in detail, shortly after commencing employment, Relator quickly discovered millions of dollars of private and government overpayments being intentionally held by PSA. Rather than reporting and returning the improper payments, PSA and its employees hid these

overpayments and created a hidden reserve fund. When Relator suggested to her supervisor and Chief Corporate Development Officer, Jonathan Solomon (who had previously had no healthcare experience) that all overpayments be returned she was told in no uncertain terms in 2011 that they should wait to see if Medicare and Medicaid "caught" these issues.

18. Jonathan Solomon, the Chief Corporate Development Officer and Head of PSA's Accounts Receivable/Business Analysis Support Center suggested that PSA "test" the return of those long due overpayments by filing a reimbursement for one with Medicaid and seeing what happened. When the Medicaid system required not only a refund of the overpayment but also of all services charged because the overpayment was more than one year old PSA advised Relator to stop her efforts to refund aging overpayments. Medicare/Medicaid only allows refunds for 12 months (365 days) from the date of service under the "Timely Filed Limit."

19. For example, under Section 6404 of the Affordable Care Act, claims with dates of service on or after January 1, 2010, received later than one year beyond the date of service will be denied. Medicare also, for example, requires overpayments to be fixed on, among other things, the Medicare Credit Balance Report on CMS-838.

20. Jonathan Solomon concluded that there should be no Medicare/Medicaid, etc. refunds for old claims, PSA began to further falsify their reporting by moving such overpayments off the reports that Relator and other billing specialists could see to a restricted set of reports called "Credit Holds" which could only be accessed only by special permission and only by a few employees other than Relator. In addition, following PSA's decision, Relator also discovered that certain old overpayments no longer properly aged in the billing system and would show as 30-120 days when in fact they were much older.

21. All PSA billing is done and controlled from its Norcross Headquarters in Peachtree Corners. CMS-838 is used to monitor identification and recovery of credit balances is "an improper or excess payment made to a provider as the result of patient billing or claims processing errors." Examples include "paid twice for the same service by either Medicare or by Medicare and another insurer." These Medicare credit balances are required to be reported "regardless of when they occurred." (See Form CMS-838 filing instructions). Form CMS-838 also states "you are responsible for reporting and repaying all improper and excess payments you have received from the time you began participating in the Medicare program." A similar report called a Credit Balance Report Form is used for Medicaid overpayments in various states including Georgia. Each of these forms requires the representative to certify that the "information is complete and accurately

reflects the provider's credit balance obligation to Medicaid". See for example, Part I Policies and Procedures for Medicaid/PeachCare for Kids, Georgia Department of Community Health Division of Medicaid, Revised: October 1, 2011.

22. CMS requires Medicare providers to submit Form CMS-838 within 30 days after the close of the calendar quarter, and include all Medicare credit balances shown in the providers accounting records as of the last day of the reporting quarter. Providers must pay all amounts owed at the time the credit balance report is submitted.

23. During her tenure at PSA, the Relator discovered numerous other billing irregularities. She attempted on various occasions to address these issues with her supervisors, knowing that she was required by law, (and by PSA's own internal policies which are clearly posed on its internal "Wiki" pages) to report any violations of which she is aware. She also advised them that the unlawful actions of the Defendants, including but not limited to, keeping and not promptly refunding overpayments from Medicare and Medicaid that the Defendants and their employees were incurring significant criminal and civil liability. In retaliation for her conduct, Relator was demoted in April 2012 from "Billing Specialist" to "Collector" and was told on or about May 2013, that her salary would be reduced from $25.00 to less than $20.00 per hour. She since experienced additional acts of retaliation by the

Defendants designed to intimidate her, have her fear for her job and impair her financial ability to support her young daughter.

24. Based on the above described provisions, *qui tam* Plaintiff and Relator McCray seeks through this action to recover all available damages, civil penalties, and other relief for state and federal violations alleged herein.

25. Although the precise amount of the loss to the federal and state Governments cannot presently be determined, it is estimated that the damages and civil penalties that may be assessed against the Defendants under the facts alleged in this Complaint amounts to tens of millions of dollars.

II. PARTIES, JURISDICTION AND VENUE

26. Plaintiff/Relator McCray is resident of Loganville, Georgia. Relator has a Bachelor's degree from Jackson State University and has been working in billing in the healthcare industry for approximately 16 years.

27. Defendant Pediatric Services of America, Inc., is a Georgia corporation with a principal address at Six Concourse Parkway, Atlanta, Georgia 30328. PSA uses the trade name PSA Healthcare.

28. Defendant PSA is a Delaware corporation with a principal office address at Six Concourse Parkway, Atlanta, Georgia 30328. PSA uses the trade name PSA Healthcare.

29. Defendant Pediatric Healthcare, Inc. is a Georgia corporation with a registered office at Six Concourse Parkway, Suite 1100, Atlanta, Georgia 30328.

30. Defendant Portfolio Logic, LLC, a Delaware limited liability company, based on information and belief (based on the Schedule 13E-3 filing with the SEC on July 3, 2007), wholly owns and controls PSA as a result of a going private transaction for an aggregate transaction value of approximately $111 million. According to Form 13D statement of beneficial ownership filing by it the SEC, Defendant Portfolio Logic, LLC has owned a controlling position of at least 10% of PSA since December 2005.

31. This is a civil action arising under the laws of the United States against the Defendants to redress violations of 31 U.S.C. §§ 3729-3730. This court has jurisdiction over the subject matter of this action: (i) pursuant to 31 U.S.C. § 3732, which specifically confers jurisdiction on this Court for actions brought pursuant to 31 U.S.C. §§ 3729 and 3730; (ii) pursuant to 28 U.S.C. § 1331, which confers federal subject matter jurisdiction; and (iii) pursuant to 28 U.S.C. § 1345 because the United States is a Plaintiff.

32. This civil action is also brought on behalf of the States of Georgia, California, Colorado, Connecticut, Florida, Illinois, Louisiana, Massachusetts, New Jersey, New York, North Carolina, Texas, Virginia and Washington against

the Defendants to redress violations ad recover damages and civil penalties as allowed under the False Claims Acts of these States.

33. This suit is not based upon prior public disclosures of allegations or transactions in a criminal, civil or administrative hearing, lawsuit or investigation or in a Government Accounting Office or Auditor General's report, hearing, audit, or investigation or from the news media.

34. To the extent that there has been a public disclosure unknown to Relator, she is the original source under 31 U.S.C. § 3730(e)(4) and the relevant state whistleblower statutes. She has direct and independent knowledge of the information on which the allegations are based.

35. This Court has jurisdiction over Defendants under 31 U.S.C. § 3732(a) because PSA can be found in, is authorized to transact business in, and is now transacting business in this District. In addition, acts proscribed by 31 U.S.C. § 3729 have occurred in this District.

36. Venue is proper in this District because Defendants conduct business in this District and, upon information and belief, acts giving rise to this action occurred within this District.

III. RELEVANT LAW

A. The Medicare and Medicaid Programs.

1. Medicare

37. In 1965, Congress enacted Title XVIII of the Social Security Act, known as the Medicare program. Medicare is a federally-funded health insurance program primarily benefiting the elderly. Entitlement to Medicare is based on age, disability or affliction with end stage renal disease. *See* 42 U.S.C. § 426, *et seq.* Part A of the Medicare Program, the Basic Plan of Hospital Insurance, authorizes payment for institutional care, including hospital services and post-hospital nursing facility care. *See* 42 U.S.C. §§ 1395c-1395i-4.

38. Part B of the Medicare Program, the Voluntary Supplemental Insurance Plan, covers the cost of services performed by physicians and certain other health care providers, both inpatient and outpatient, if the services are medically necessary and directly and personally provided by the provider. Medicare pays providers only for services that it considers "reasonable and necessary for the diagnosis or treatment of illness or injury...." Social Security Act § 1862(a)(1)(A).

39. Providers who wish to participate in the Medicare program must ensure, among other things, that their services are provided "economically and only when, and to the extent, medically necessary." 42 U.S.C. § 1320c-5(a).

40. The Medicare program is administered through the Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS").

41. To assist in the administration of Medicare Part A, CMS contracts with "fiscal intermediaries." 42 U.S.C. § 1395h. Fiscal intermediaries, typically insurance companies, are responsible for processing and paying claims and auditing cost reports.

42. Under Medicare Part A, CMS makes payments retrospectively to hospitals for inpatient services. Medicare enters into provider agreements with providers to establish the provider's eligibility to participate in the Medicare program. Regulations for Medicare reimbursement include an annual review of healthcare operations and provide criteria for coverage and reimbursement. On information and belief, PSA is Medicare certified to provide nursing care in at least 13 states.

43. As a prerequisite to payment for Medicare, CMS requires home health agencies to submit annually a Form CMS-1728 (previously Form HCFA-1728), more commonly known as the Cost Report. Cost Reports are the final claim that a provider submits to the fiscal intermediary for items and services rendered to Medicare beneficiaries.

44. Home Health Agency Cost Report contains a "Certification" that must be signed by an officer or director of the Home Health Agency as follows:

> Sections 1877(a) and 1901(a)(1) of the Social Security Act state that, "Whoever knowingly and willfully makes or causes to be made any false statement or representation of material fact in any application for any benefit or payment under this title–shall (i) in the case of such a statement, representation, concealment, failure or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than 5 years, or both, or (ii) in the case of such statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than 1 year or both."

45. A home health care agency is required to disclose all errors and omission in its claim for Medicare reimbursement (including its cost reports) to its fiscal intermediary. 42 U.S.C. § 1320a-7b(a)(3) specifically creates a duty to disclose known errors in cost reports.

> Whosoever . . . having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment . . . conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such payment or benefit is authorized . . . shall in the case of such a . . . concealment or failure . . . be guilty of a felony.

> The Medicare Secondary Payer (MSP) Manual (Rev. 87, 08-03-12) (www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c03.pdf) regulations at 42 CFR 489.20 require providers to pay Medicare within 60 days from the date a payment is received from another payer (primary to Medicare) for the same service for which Medicare paid. A provider refunds the Medicare

> payment within 60 days by submitted an adjustment bill or via the Medicare Credit Balance Report. The MSP regulations at 42 CFR 411.24(h) and 411.25 require all entities that receive a primary payment from both Medicare and a primary plan to repay Medicare. A physician or other supplier submits a refund check to Medicare. This refund is due Medicare, regardless of which payment the provider, physician, or other supplier received first and even if the insurance payment was refunded to the beneficiary or the insurer.
>
> Providers report credit balances resulting from MSP payments on the Form CMS-838 if the overpayment has not been repaid by the last day of the reporting quarter. If the provider identifies and repays an MSP credit balance within a reporting quarter, in accordance with the 60-day requirement, it is not reported on the Form CMS-838, i.e., once payment is made, a credit balance would no longer be reflected in the provider records.
>
> If an MSP credit balance occurs late in a report quarter, and the Form CMS-838 is due prior to expiration of the 60-day requirement, the overpayment must be included in the credit balance report. However, payment of the credit balance does not have to be made at the time the Form CMS-838 is submitted, but within the 60 days allowed.

46. Under Medicare Part B, "Medicare carriers" are responsible for accepting and paying claims for certain reimbursements under Medicare Part B.

47. In addition, each provider must sign a provider agreement as a condition of participation that agrees to comply with all Medicare requirements including the fraud and abuse provisions. A provider who fails to comply with these statutes and regulations is not entitled to payment for services rendered to Medicare patients. By submitting a claim for Medicare reimbursement, the provider certifies that the submitted claim is eligible for Medicare reimbursement and that the provider is in compliance with all Medicare requirements.

48. Medicare beneficiaries receiving home health care may also be eligible for Medicaid, depending on their financial resources or disability status. Some Medicaid programs have been known to employ "Medicare Maximization" to shift dollars from Medicaid to Medicare.

49. In 2010, Medicare paid $19.5 billion to 11,203 home health agencies ("HHA") for services provided to 34 million beneficiaries. Recent investigations and prior Office of Inspector General Studies have found that home healthcare services are vulnerable to fraud, waste and abuse. (See Department of Health and Human Services, Office of Inspector General "Inappropriate and Questionable Billing by Medicare Home Health Agencies" (August 2012) OEI-04-11-00240).

2. Medicaid/Tricare/Champus/Indian Health Services

50. Medicaid was also created in 1965 under Title XIX of the Social Security Act. Funding for Medicaid is shared between the Federal Government and those states participating in the program. Thus, under Title XIX of the Social Security Act ("Medicaid"), 42 U.S.C. § 1396 *et seq.*, federal money is distributed to the states, which in turn provide certain medical services to the poor. Federal Medicaid regulations require each state to designate a single state agency responsible for the Medicaid program. The agency must create and implement a "plan for medical assistance" that is consistent with the Title XIX and with the regulations of the Secretary of the United States Department of Health and Human

Services (the "Secretary"). After the Secretary approves the plan submitted by the State, the state is entitled each quarter to be reimbursed for a percentage of its expenditures made in providing specific types of "medical assistance" under the plan. 42 U.S.C. § 1396(a)(1). This reimbursement is called "federal financial participation" ("FFP").

51. All Medicaid State plans must cover a certain set of basic benefits ("mandatory benefits"). These benefits include but are not limited to inpatient and outpatient hospital services; rural health online services; federally qualified health center services; laboratory and x-ray services; physician services and certain home health care benefits.

52. Each state's Medicaid program must cover certain home healthcare benefits.

53. In Georgia for example, the Georgia Department of Community Health, Division of Medicaid/PeachCare for Kids Program (See Part I Policies and Procedures for Medicaid/PeachCare for Kids). Section 3.034 of the Part I – Policies and Procedures Manual prohibits a provider from filing claims under Medicaid when it learns that a third party might be responsible or for example filing claims with Medicaid and subsequently billing the third party carrier. Home Health Agencies such as PSA are also required to file Medicaid Credit Balance Report Forms due to an outstanding overpayment or credit balance. In addition, as

a condition to participation in the Medicaid program, providers are required to certify in Georgia for example as follows (APPENDIX L Billing Manual, Attestation of Compliance) as follows:

> I hereby attest that, as a condition for the above-identified Covered Entity to receive payments under the Georgia Medicaid/PeachCare for Kids Program, I have read Section 6032 if the Deficit Reduction Act of 2005 (the Act) and confirm that:
>
> - The Covered Entity's policies and procedures contain detailed information about the Federal laws identified in Section 6032(A) and about Georgia's laws imposing civil or criminal penalties for false claims and statements, and about whistleblower protections under such laws as found in the Sate False Medicaid Claims Act, Article 7B of Chapter 4 of Title 49 of the Official Code of Georgia; and
>
> - The Covered Entity's written policies and procedures also contain detailed information regarding its own policies and procedures to detect and prevent fraud, waste and abuse in Federal health care programs, including the Medicare and Medicaid Programs; and
>
> - The Covered Entity provides copies of its written policies to its employees (including management), and to any of its contractors and agents that perform billing or coding functions for the Covered Entity, or that furnish or authorize the furnishing of Medicaid health care items or services on behalf of the Covered Entity, or that are involved in monitoring of health care provided by the Covered Entity; and
>
> - The Covered Entity's written policies and procedures are included in any employee handbook maintained by the Covered Entity.
>
> I also confirm that the Covered Entity includes the Georgia Medicaid/PeachCare for Kids providers identified on Attachment A.

54. Most states have adopted similar certification as a result of that Deficient Reduction Act of 2005.

55. Each home healthcare agency that participates in the Medicaid program must sign a Medicaid provider agreement with his or her state. Although there are variations in the agreements among the states, all states require the prospective Medicaid provider to agree that he/she will comply with all Medicaid requirements, including the fraud and abuse provisions.

56. Tricare/Champus, administered by the United States Department of Defense, is a health care program for individuals and dependents affiliated with the armed forces. The Federal Employee Health Benefit Program, administered by the United States Office of Personnel Management, provides health insurance for federal employees, retirees, and survivors. 10 U.S.C. §§ 1971-1104; 32 C.F.R. § 1999.4(a).

57. Indian Health Services ("IHS"), a division of the Department of Health and Human Services, is the Federal Health Program for American Indians and Alaska Natives. The Indian Health Care Improvement Act of 1976 allows IHS to bill for medical services provided by IHS facilities to Indians eligible for Medicare and Medicaid.

58. In various states Medicaid programs, including the state of Georgia, since 2000, home health agencies are required to file electronic cost reports. (See

42 C.F.R. Part 413.24(f)(4)) (Home Health Cost Data Form) which includes information and certifications of CMS Form 1728 previously described herein (see www.dch.georgia.gov/home-health).

59. In various states' Medicaid programs, home health agencies and other providers, are required by virtue of state law and Provider Agreements to promptly return overpayments as soon as it is discovered or reasonably should have been or similar language. (See for example New York, Florida and Texas provider agreements.)

IV. DECEPTIVE CONCEALING AND FAILURE TO PROMPTLY REPORT AND RETURN OVERPAYMENTS

60. Relator Sheila McCray was hired as "Accounts Receivable Specialist" on or about August 15, 2011 and was listed as reporting to Sonya Simpson, Accounts Receivable Manager. Sonya Simpson reported to Chief Corporate Development Officer Jonathan Solomon, who, according to PSA's corporate organizational chart dated January 17, 2013, reported directly to PSA's President & CEO James McCurry (Both Sonya Simpson and Jonathan Solomon have resigned from employment with Defendants' since Relator filed her original Complaint).

61. Relator was initially hired to perform "reconciliations" and "credits" on accounts and was responsible for the PSA offices in Greenville and Columbia, South Carolina, Northern Virginia and Washington, D.C.

62. Within one month of being hired, on September 30, 2011, Related received an email from David Malloy (copy to Jonathan Solomon), Director of Shared Services at PSA (from July 2010 – June 2012 per www.linkedin.com praising Relator for resolving "1/7 of our credit problems on commercial insurances." A copy of that email is attached as Exhibit "A". On information and belief, David Molloy had no healthcare experience.

63. Relator quickly learned from the weekly and monthly accounts receivable and credit balance reports for all states that there were over $3,000,000 of easily observed "credits" or overpayments made to what appeared to have been patient accounts which had been sitting on the books for up to 3 years! Relator noticed that the greatest number of these overpayments were from State Medicaid payors.

64. All billing and collections for PSA offices was performed at PSA's Peachtree Corners, Georgia location and was done electronically.

65. Concerned that PSA was violating Federal and State law by not promptly returning overpayments and violating its own policies and procedures on refunds which require refund and recoupment 30 days of receipt (See Exhibit "B"), Relator approached her immediate Supervisor, Sonya Simpson and was told "not to worry about it." Still concerned as the credits (overpayments) continued to grow and aging credits continued to accumulate, Relator approached PSA Director

David Molloy and Sonya Simpson's boss Jonathan Solomon, about PSA's legal obligation to return those large credits (overpayments). Relator told them on more than one occasion that these unlawful actions would cause significant criminal and civil liability. Solomon who was hired in September 2010 previously had no healthcare experience and was previously employed in finance and social media.

66. Relator was also told that if the amount owed was $600.00 or less than PSA "would keep it" and those amounts were removed from reports she would see.

67. Relator also observed that often, if a patient had primary and secondary insurance, PSA would bill Medicaid or Medicare first, then "delete and rekey," for example, Blue Cross and Blue Shield, and often not return the payment received by Medicaid or Medicare and notify them that another insurance carrier is primarily in violation of federal and state law.

68. Relator also observed that there were a number of instances where PSA would bill licensed nurse practitioners (LPN's) as registered nurses (RN's). Relator discussed the issue with then 14-year PSA employee and "Refund Specialist" Melanie Moore and Melanie Moore told Relator that she was instructed by Jonathan Solomon not to issue credits or reimbursements after 1 year.

69. In February 2012, Relator against spoke with Melanie Moore and asked about how refunds were proceeding for Melanie's team, which was headed by Reimbursement Manager Tekelia Brooks (who also reported to Jonathan

Solomon). Melanie Moore responded by telling Relator that PSA had over $600,000 in credits in Pennsylvania alone and if PSA did the adjustments/credits, "We would lose that money" due to the "Timely Filing Rule." Relator understood this Timely Refund Rule to mean that if funds were not returned in the time periods prescribed by federal and various state laws that any attempt to refund overpayments would cause the entire billed amount to be recouped. PSA maintained on their internal Company intranet a complete list of state and federal timing requirements for, among other things, claims submissions, corrections, refunds and overpayments.

70. At the same time in February 2012, Relator learned that Tekelia Brooks also told her staff not to do any reimbursements for Texas.

71. On February 10, 2012, a meeting was held at PSA's Peachtree Corners offices to discuss how PSA could "absorb" credits over one year old so as not to refund the money and risk that Medicaid (estimated at 90% of revenues) or other insurers could recoup all billings. In attendance were Jonathan Solomon, Tekelia Brooks, Sonya Simpson, David Molloy and Relator. Relator became even more upset and concerned when she learned at the meeting that her supervisors were illegally conspiring to keep and hide many millions in refunds and put them in a special "reserve account."

72. On February 10, 2012, Relator sent an email to David Molloy and Jonathan Solomon regarding her efforts at resolving commercial credits and advising them that Relator "was working on Medicaid voids through the portal for duplicate payments." (See Exhibit "C").

73. Approximately one hour later, at 12:01 PM, Relator received an email from Sonya Simpson, copied to David Molloy, telling her "as we discussed at today's meeting, please be sure we are testing one claim on those voids through the web portal for overpayments." (See Exhibit "C").

74. Within fifteen minutes of Sonya Simpson's email, Relator received an email from Jonathan Solomon stating, "Would it make sense to actually call Medicaid first to make sure we know how this works. Also, can I get some feedback on what we are seeing (reasons) for the Medicaid Credits." (See Exhibit "D").

75. Six minutes after Jonathan Solomon's email, David Molloy responded among other things, "We choreographed the process out yesterday beginning to end," and asked Sonya to "walk Jonathan through what we will do." (See Exhibit "E").

76. Relator learned that at Jonathan Solomon's directions, PSA had determined to file an "adjustment" (credit) for one claim to determine the

recoupment by Medicaid. PSA had determined that if Medicaid did recoup the entire claim "we will not do anymore adjustments until we find another solution."

77. After that one claim was filed, Medicaid did in fact recoup the entire billings for the claim over the adjustment filings period.[2]

78. Shortly thereafter, Relator had another meeting with Jonathan Solomon, Tekelia Brooks, Sonya Simpson and David Molloy. PSA agreed not to bill any more claims over the (state's or federal) "Timely Filing Rule" "until further notice."

79. In early April 2012, Relator learned that PSA had determined to move its older credits for Medicaid and other payors off the account receivable and credit reports that she and her counterparts could see. This was accomplished, she learned by PSA adding a "delete and rekey" function and creating hidden secret subaccounts away from billing staff and auditors.

80. Attached as Exhibit "F" is an April 3, 2012 email Relator, Jonathan Solomon and David Malloy received from Lori Moore, Director of Applications Development and Support, PSA's head of IT and in charge of computer programming for billing that describes adding the "delete and re-key for credit."

81. Relator was also copied on a follow up email from Jonathan Solomon to Lori Moore and David Molloy, copied to Opal Ferraro, the CFO of PSA

2 Relator had observed such a recoupment for a patient in South Carolina.

regarding the delete and rekey function. (See Exhibit "F"). This email shows that the issue of these credits and "delete and rekey" effort to hide and keep these credits had been discussed with Solomon's boss, the then CEO, Jim McCurry, but also PSA CEO Opal Ferraro!

82. According to published reports, CFO Ferraro, began her employment at PSA in May 2010 after 3 years as CEO of 3 Day Blinds Corporation, 17 months at Party America and start-up retailer, Babbage's, a start-up retailer. She succeeded Steve Russell as CFO who also appears not to have had previous healthcare and wound up in the automotive industry. According to published reports, Jim McCurry became CEO of PSA in December 2008, succeeding Daniel J. Kohl (www.linkedin.com). Mr. McCurry appears not to have had any previous healthcare experience was co-founder and chairman of Babbage's, Inc.

83. While the email states "those duplicates that are only Medicaid – give money back," Relator believes that this was only lip services and continued to learn that this delete and rekey feature is PSA's proprietary and centralized "Encore Billing System" controlled by Melanie Moore, could be adjusted with her consent to show these hidden credits as necessary for billing and collections.

84. At this time in April 2012, Relator learned suddenly that her job position had been changed (with the same salary) from taking care of "credits" to "Billing Specialist."

85. In a number of instances, Relator was able to approach Melanie Moore to get a release of credit information held off the accounting system (the so-called "credit hold") so Relator could process several refunds credit. Relator learned on or about May 2012 that David Molloy suddenly resigned and moved to Arizona.

86. By December 2012, Relator was still concerned that the old Medicaid overpayments had not been resolved and refunded.

87. On December 10, 2012, she emailed her supervisor suggesting that she do the refunds for claims that were over 365 days and due to Medicaid. Five minutes later, Sonya Simpson replied, "You can leave the adjustments for now – we will circle back to those. Right now our focus is on the open A/R . . . unless the credit affects the debit balance (See Exhibit "G"). It was clear to Relator that PSA would keep all those credits.

88. At about that time, Relator discovered that credits showing in the A/R and related credit reports showing 120 days were actually much older and in many cases over 1 year old! (See for example Exhibit "H"). She could see from the claim numbers when researching these files (with permission) what the dates of service actually were.

89. In a number of occasions as further evidence of this scheme by PSA to keep the credits and move them off PSA's books, Relator could not find

"credits" that had previously been in prior reports. Sonya Simpson told Relator to speak with Lori Moore to see if it was in the "permission holding." In those instances Melanie Moore moved the credits back in the A/R reports.

90. Relator has continued to question the practice of retaining these Medicaid credits.

91. On or about April 2013, Relator was told by her supervisor, Sonya Simpson, that her salary was being reduced by 25% and was provided with no stated reason other than that Francis Scovil, PSA Director of Corporate Service Center and who had reported to Jonathan Solomon said that Relator's salary was "too high for a 'Collector.'" Relator knew she was being punished and harassed for reporting PSA's wrongdoing and attempting to properly issue all refunds as required by law. As a single mother and homeowner, PSA knew that as a result of this sudden and unjustified significant pay cut Relator would be forced to look for another position.

92. Relator has also just recently learned on May 10, 2013 (in an email from CEO Jim McCurry) that PSA has replaced its Chief Compliance Officer (Vice President Audit & Compliance) Deborah Hall, who served from November 2011 to April 2013 and does not know the reason for her departure. Her successor is Patrick Cunningham.

V. PSA's COMPLIANCE POLICIES

93. PSA has a significant number of published Compliance Policies relating to assuring Compliance with all relevant Federal, State and local laws and regulations. The Compliance Policies were available on PSA's intranet.

94. As stated in the "PSA Healthcare Compliance Program" memo, among other things. . .

> (5) The Company maintains an "open door" policy for reporting issues and concerns. . . . Lastly, in order to ensure open and candid reporting, the Company has formally established a Non-Retaliation policy which empowers workforce members to report voice allegations or concerns without fear of reprisal or retribution.
>
> (7) The Company has established formal processes to facilitate the appropriate response and correction of violations of law, regulation, policy, etc. A formal protocol has been established for the investigation and resolution of compliance issues, including measures to prevent similar conduct.
>
> Any supervisor who receives a complaint or report of misconduct concerning a potential compliance issue is required to promptly notify the CCO for investigation and follow up.

95. The PSA Compliance with Local, State and Federal Laws and Regulations states:

> All workforce members are expected to be familiar and comply with all clinical, legal, regulatory and ethical requirements that pertain to the performance of their assigned duties and responsibilities.
>
> PLSA maintains both an open door policy, as well as, a non-retaliation – intimidation policy to facility open and candid communications without fear of reprisal.

96. PSA' Suspected Fraudulent Documentation memo states, among other things:

> Federal and State False Claims acts prohibit the knowing and/or use of false or fraudulent claims, records or statements for the purpose of obtaining payment from any government funded program. These laws apply to Medicare and Medicaid program reimbursement . . . falsifying cost reports; . . . participating in kickbacks; and retaining overpayment for services or items.
>
> A violation may result in civil, criminal and/or administrative penalties, including monetary penalties (treble damages), imprisonment, and exclusion from participation in federally funded programs such as Medicare and Medicaid, and loss of licensure status.
>
> Any location manager who suspects that an employee . . . has submitted falsified documents with respect to the provision or billion ordered services shall immediately notify the Chief Compliance Officer and the VP of Business Operations of the potential wrongdoing.

97. This memo goes on to describe corrective action which was not to Relator's knowledge taken in this matter:

> Upon completion of the investigation, or when facts support wrongdoing, the CCO will coordinate with the VP of People Services, General Counsel, VP of Business Operations, Corporate Reimbursement Manager, etc. to determine the appropriate corrective action based on the facts and circumstances. This may include:
>
> - Notifying the payor source of the issue and pending reimbursement, if applicable
> - Contacting the appropriate regulatory and legal authorities.
>
> Based on the circumstances, the CCO may also recommend "global" (e.g. policy revisions, training, other audits regarding similar scenarios, etc.) in order to prevent future similar occurrences.

98. Finally PSA's Compliance Corrective Action memo is most telling stating and incriminating in this case, among other things:

> When a compliance investigation confirms that a violation of law, regulation or Company policy has occurred, the CCO has a responsibility to report such find and recommend appropriate corrective action. Depending on the circumstances, self-disclosure may also be required ("voluntarily" self-reporting matters of noncompliance). For example, the False Claims Act (FCA) and the Patient Protection and Affordable Care Act (PPACA) arguably create a duty to disclose a known false claim or overpayment. Self-disclosures are generally required to be filed within 60 days from the time that PSA became aware of the matter; however, to whom the disclosure should be made is very much a case-by-case determination.
>
> The OIG's Compliance Program Guidance not only requires prompt and effective correction action specific to the violation (e.g., disciplinary action, reporting and refund, etc.), but also requires that reasonable steps be taken to prevent similar problems in the future. This type of corrective action is generally more global in nature and includes, but is not limited to:
>
> - revising policies and procedures;
> - altering existing operating processes;
> - altering or enhancing internal controls;
> - modifying or developing training programs;
> - implementing a corporate communication plan to reinforce existing policies or changes.
> - All workforce members are expected to be familiar and comply with all clinical, legal, regulatory and ethical requirements that pertain to the performance of their assigned duties and responsibilities.

99. Had the scheme described herein to conceal and keep overpayments been known to officials with the State Medicaid programs, all payments would

have been terminated and no funds from Medicare or Medicaid would have been paid to PSA.

100. In the alternative, PSA would never have been allowed to enter into contracts with Medicaid and Medicare, and none of the contracts between Medicare/Medicaid and PSA existing at the time that this scheme commenced would have been renewed.

101. The fraudulent schemes described in Paragraphs 1 – 100 of the Original Complaint continue unabated through the date hereof.[3]

102. Defendants have engaged in a massive cover-up, have engaged in significant additional fraudulent conduct, and continue to submit false claims to the United States Government to hide their illegal and unlawful conduct, as described herein.

VI. ILLEGAL BILLING OF ALL CAPC PATIENTS IN NORTH CAROLINA UNDER CARY NORTH CAROLINA BILLING NUMBER

103. Relator had a serious slip and fall while working at Defendants' office and was unable to work for the Defendants from April 13, 2013 until October 19, 2013. Relator was forced to take unpaid leave, received medical treatment and therapy for her injuries, and filed for disability which Defendants have contested and denied her claim. Upon her return to work in an effort to cause Relator's termination due to her questioning and contesting certain of Defendants' billing

3 Terms of art used in this pleading have the same meaning as those used in the Original Complaint.

and collections practices, Defendants, without notice to Relator unfairly and illegally deducted 100% of her first paycheck in six months, claiming Relator had to first pay back all of her health insurance premiums of approximately $1,800.00 incurred while she was out on disability. Defendants have refused to pay Relator's medical expenses of approximately to date $13,000 including her ambulance bill. Relator's take home bi-monthly pay is only approximately $1,600.00. Relator complained to Defendants that as a single mother, she could not afford not to receiver her salary and Defendants determined to have Relator pay, via payroll deduction a whopping $400.00 or 25% of her take home paycheck bi-weekly, reducing her take home pay to $1,000.00 bi-weekly! Relator believes that this is further retaliation against her for questioning Defendants' practices and is an attempt by Defendants to force Relator's resignation.

104. Defendants have since Relator's return, without explanation reassigned Relator as an AR Collector for a single PSA facility in Greenville, North Carolina.

105. Since returning to work, Relator has observed and overheard continued misconduct by Defendants and their employees constituting the submission of continued false claims under FCA and the State Acts.

106. On her very first day back to work on October 19, 2013, Relator came to learn that Defendants were wrongfully and illegally billing all CAP/C patients in

North Carolina under Defendants' Cary, North Carolina Billing Number 114955309. According to the DHHS N.C. Department of Health and Human Services website (http://www.ncdhhs.gov/dma/medicaid/capchildren.htm), CAP/C is the community Alternatives Program for Children (CAP/C) (also known as the Katie Beckett waiver) provides home and community based services to medically fragile children who, because of their medical needs are at risk for institutionalization in a nursing home. Examples of children who may be eligible for CAP/C include children with ventilators, tracheostomies, feeding tubes, severe seizures, and those children who need help with activities such as bathing, dressing, grooming, and toileting when the child, for medical reasons, is not able to do or learn to do those tasks independently. All families on CAP/C have a case manager to assist them with identifying their needs, developing a plan of care to meet those needs, and monitoring and coordinating the services and supplies in that plan of care. In addition to case management, families must require and use one of the following additional services, at least once every 90 days: (i) in-home nurse or nurse aide care; (ii) certain home modifications and vehicle modifications to enhance the child's safety and independence; (iii) palliative care (art therapy, music therapy, counseling, and bereavement counseling offered both to the child and to the family); (iv) adaptive tricycle; and (v) caregiving training and education (funding of the registration fee or tuition for workshop, seminar, or class that will

enhance a caregiver's ability to provide care). Additional services available to families who already receive case management and one of the above services include: (i) respite care (in-home or institutional nursing care provided in order to give the child's caregiving some leisure time; and (ii) re-usable diapers and the disposable liners used with them. Children on CAP/C also have access to regular Medicaid services, for example, physical therapy, occupational therapy, speech therapy, and medical equipment. CAP/C is available to any child birth through 20 years of age of meets both the Medicaid eligibility criteria and the CAP/C eligibility criteria. The Medicaid criteria for CAP programs are not the same as the regular Medicaid criteria. CAP/C criteria include that the child must live in a private residence, must be able to be cared for safely at home, must require same level of care as a child in a nursing home or hospital, and must have a family willing to participate in the care and in the care planning for their child.

107. On information and belief, Defendants have six other locations in North Carolina, including Charlotte, Bloomington, Greenville, Winston Salem, Raleigh and Fayetteville, all of whom Relator learned are wrongfully billing CAP/C sources under the Cary, North Carolina NPI number for CAP/C patients.

108. Concerned, Relator approached her PSA Supervisors, Accounts Receivable Manager Kelly Altieri, Acting Supervisor Elaine Thompson and co-biller Sonya Lundie about this practice and was told to change the NPI number for

all North Carolina CAP/C patients to the Cary, North Carolina Number 114955309. Relator's supervisors when questioned numerous times by Relator said, "That PSA was trying to get things done by location". Relator believes that Defendants are fraudulent billing approximately $100,000.00 per week alone involving treatments from the Greenville Office. Relator has confirmed with Cheryl Prather, Nateesha Decosmo and Fernesa Rogers, the other billers for North Carolina that they were instructed to use the Carey, North Carolina NPI number for all North Carolina locations. Relator has retained copies of the Form 1500 filings for patient 1000 for many claims Relator was instructed to file relating to patient 1000 from Defendants' Greenville, North Carolina office which were billed to the Cary, North Carolina NPI number in Box 339 of that Form.

109. Still concerned that Relator was violating the law, on November 11, 2013, Relator emailed her supervisor again questioning this practice. (See Exhibit "I"). On November 12, 2013, Kim Altieri responded to Relator's email and forwarded a string of emails from October 25 – October 28 which include PSA supervisors and executives Kathi Miller, Frances Scoville, Marcia Gilreath and Vicki Whiteside detailing this fraudulent practice. (See Exhibit "J"). This email trails lists several other billing issues involving various PSA officers including restrictions of billing of supplies for PDN, CAP/C and the In-Home Supports.

VII. INTENTIONAL AND ILLEGAL UNDERREPORTING OF PRIMARY CO-PAYMENTS BY DEFENDANTS TO FLORIDA MEDICAID TO ILLEGALLY OBTAIN HIGHER REIMBURSEMENTS FROM FLORIDA MEDICAID AND OTHER MEDICAID, MEDICARE AND OTHER PROVIDERS

110. Relator has recently learned that Buffie Brown, one of the collectors for Defendants for the State of Florida has been advised by her supervisors to illegally underreport payments received by primary insurance carriers where Florida Medicaid is secondary in order to obtain higher reimbursements. In many instances this intentional underreporting of payments is done to avoid write offs and to procure higher reimbursements then allowable under Florida Medicaid rules. This practice involves the direct knowledge of supervisors of Defendants' management including Kelly Altieri, who joined PSA in September 2013, Elaine Thompson, Acting Supervisor and Kelly Altieri's supervisor and Francis Scoville PSA Director of Corporate Service Center

111. For example, Exhibit "K" attached herein, shows a billing report for patient 1001, for licensed nurse practitioner care on April 11, 2011 that primary insurer Aetna paid $401.60 and Exhibit "L" shows that secondary insurer Florida Medicaid paid $110.56 on November 29, 2011 and $168.80 on April 13, 2012. Also shown is a Medicaid co-pay disallowed of $202.56. In order to get payment of this disallowed charge, Buffie Brown was instructed by her supervisor to update the secondary payment information TPL (third party liability) amount on the

Florida Medicaid Portal to reflect a TPL amount of $279.36 instead of the actual amount paid by Aetna which was $401.60! See Exhibit "M" on bottom right of page 1. Uncomfortable with illegally underreporting the TPL amount from Aetna, Buffie Brown was careful to document her having received these instructions from her supervisor Elaine Thompson. (See Exhibit "N"). Ms. Brown clearly states that she updated secondary payment on the Medicaid Portal per Elaine to update the TPL amount to reflect the remaining 12 hours at $279.36 (Medicaid allowed amount $23.28 times 12 hours) . . . to be an additional $591.36 . . . Relator has come to learn that this is a common and pervasive practice of Defendant without State Medicaid, Medicare and other providers.

112. In this example, by claiming that the primary insurer only paid $279.36 for 12 hours (units) of treatment, Defendants obtained a higher reimbursement from Florida Medicaid of $202.56 instead of obtaining no reimbursement at all.

113. On information and belief, Realtor believes in addition to the State of Florida that this is also a practice of Defendants' in other states as well.

VIII. INTENTIONAL AND ILLEGAL NON-REPORTING OF PRIMARY CO-PAYMENTS BY DEFENDANTS TO MEDICAID OF ILLINOIS AND PENNSYLVANIA OF PRIMARY CO-PAYMENTS

114. Relator has recently learned from Janis Bell, a denial specialist who was on Tequila Brooks' team, that Defendants are intentionally omitting any co-

payments received from primary insurers from Illinois and Pennsylvania Medicaid submissions. Janis Bell told Relator that she was told to not include these co-payments as Medicaid Illinois and Pennsylvania has denied payment claims where there was a co-payment from a primary insurer.

115. Ms. Bell was told to file the HCFA Form 1500 or through the Medicaid Portal to omit from Box 29 any co-payment from the primary insurer. (See Exhibit "O").

IX. INTENTIONAL AND ILLEGAL UPCODING OF CHARGES FOR HOME HEALTH CARE SERVICES TO ALL STATE MEDICAIDS

116. Relator has also discovered that Defendants are illegally upcoding for home health care services to State Medicaid providers. For example, Florida Medicaid does not permit billing for services equal to 30 minutes or less.

117. Relator understands that billers have been instructed by Defendants to bill .5 (30 minutes) and up units as 1 full unit (1 hour) on the Encore Billing System of the Defendants. Relator also believes that Encore Billing System may do it automatically. A simple comparison with the actual time entered by hours will substantial this wrongful practice.

118. Exhibit "P" attached herewith are pages A-2 and A-3 of the Florida Home Health Services Coverage and Limitations Handbook, which details the maximum fee permitted per hour for various home health services. On page A-3 therein it states, "Any portion of the hour that exceeds 30 minutes may be rounded

up to the next hour, but the total may not exceed the daily authorized number of hours."

119. Exhibit "Q" attached herewith shows various in home care by a licensed nurse practitioner for patient 1002 for certain days in the month of August 2012. It shows at least three .5 charges that were falsely and incorrectly submitted to and paid by Florida Medicaid (8/7 and 8/10). A review of reports from Defendants IT reports from the nurse's actual recorded time and notes will reveal this long and extensive fraudulent practice. That means if the claim is less or equal to 30 minutes, it cannot be rounded up to one hour.

120. Many State Medicaid Agencies also do not permit 30 minutes or less to be billed. Relator has been advised that Defendants are illegally marking up the minutes they bill for private duty nursing and home healthcare for all States.

121. Upon information and belief, Relator believes that the practice may also be occurring in other states.

X. INTENTIONAL AND ILLEGAL BILLING BY DEFENDANTS TO FLORIDA MEDICAID PRIOR TO FINALIZATION OF TREATMENT NOTES, REQUIRED FLORIDA AUTHORIZATIONS OR TREATMENT PLANS ENTERED INTO THE SYSTEM

122. Relator has recently learned in conversations with biller Sonya Lundie and biller Kelly Davenport that Defendants are billing claims to Florida Medicaid before the physician signs off on his notes, a plan of treatment is entered in the system or Defendants have obtained authorization from Florida Medicaid. This

results in patients not being properly received and treated by Defendants employees!

123. Relator believes that the same thing has occurred over time under Tequila Brooks' collection team for Medicaid in the States of Illinois, Pennsylvania and other states.

XI. DEFENDANTS HAVE ALSO CONCEALED FROM SECONDARY MEDICAID STATE PAYORS AND FAILED TO REPORT CERTAIN SITUATIONS WHERE SECONDARY INSURER HAS PAID CLAIMS BEFORE PRIMARY INSURER

124. Relator has recently learned that Defendants also have illegally retained and hid payments from Secondary State Medicaid providers which were wrongfully billed before the primary insurer was billed for the service. Relator has discovered a "Pre-Pay Report" which details this illegal activity. Exhibit "R" details a selected sample of such illegal payments from State Medicaid in the States of Florida, Georgia, North Carolina and Washington, and some in South Carolina and Georgia dating back to 2009!

XII. DEFENDANTS HAVE BEEN SYSTEMATICALLY WRITING OFF SMALL UNPAID BALANCES FOR PATIENTS RESULTING IN AN ILLEGAL KICK BACK SCHEME IN VARIOUS STATES

125. Relator has recently learned that Defendants have for years systematically and routinely writing off from collection small unpaid co-pay balances from patients. Relator is aware of a Small Balance Write-Off Account controlled by Melanie Moore. At a Compliance Meeting recently held at PSA's

Atlanta Headquarters in a slide presentation, Defendants' new Chief Compliance Officer, Doddie Sutton, who has been on the job just a few months admitted that such write-offs by Defendants constitute a violation of the Act and State Acts referenced herein and an illegal kickback under Federal Anti-Kickback Statute (42 U.S.C. § 1320-7b(b)) (the "Anti-Kickback Statute") and state Anti-Kickback Statutes ("State Anti-Kickback Statutes") and other applicable laws.

126. The Anti-Kickback statute also makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. See section 1128B(b) of the Act. Where remuneration is paid purposefully to induce or reward referrals of items or services payable by a Federal health care program, the anti-kickback statute is violated. By its terms, the statute ascribes criminal liability to parties on both sides of an impermissible "kickback" transaction. For purposes of the Anti-Kickback Statute, "remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

127. Violation of the statute also constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to five years, or both. Conviction will also lead to automatic exclusion from Federal health care programs, including Medicare and Medicaid. Where a party commits an act described in section

1128B(b) of the Act, The Office of the Inspector General ("OIG") may also initiate administrative proceedings to exclude such party from the Federal health care programs under section 1128(b)(7) of the Act.[4]

128. In effect, by writing off the co-payments that the patients have contractually agreed to pay, this creates an incentive for the patient to refer patients to the Defendants and not to its competitors. Waivers of co-payments and deductibles are specifically included under the definition of "remuneration". In addition, such practice violates the applicable Medicaid, Medicare and other applicable provider contracts which requires the Defendant to collect the co-pay and deductible. Such practice also violates the Health Insurance Portability and Accounting Act of 1996 ("HIPPA") Section 231 (Pub. L. 104-191, 110 Stat. 1936 (enacted August 21, 1996) which requires healthcare providers to collect a co-pay or deductible and the failure to do so constitutes fraud.[5] Under HIPPA, it is

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4 In a 1994 Special Fraud Alert released by the OIG for the U.S. Department of Health and Human Services, the "routine" waiver of Medicare Part B copayments and deductibles was identified as a violation of the Federal Anti-Kickback Statute and False Claims Act. In 1996, Congress added 42 U.S.C. § 1320a-7a(a)(5) to the Anti-Kickback Statute, imposing a civil monetary penalty upon a person who offers or transfers to a Medicare or Medicaid beneficiary any remuneration that the person knows or should know is likely to influence the beneficiary's selection of a particular provided, practitioner, or supplier of Medicare of Medicaid payable items or services. The amendment expanded the definition of "remuneration" to the beneficiary to include, without limitation, "waivers of copayments and deductible amounts (or any part thereof)."

5 Section 231(h) defines "remuneration" as including, *inter alia,* the waiver of coinsurance and deductible amounts (or any part thereof). Waivers of coinsurance and deductible amounts are expected from the definition of remuneration if: (i) the waiver is not offered as part of any advertisement or solicitation; (ii) the person making the waiver does not routinely waive coinsurance or deductible amounts; and (iii) the person making the waiver (a) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need; or (b) fails to collect coinsurance or deductible amounts after making reasonable collection efforts.

considered mail fraud to have a scheme intended to "defraud any health care benefit program" which is a crime under federal law.[6]

129. The U.S. Department of Health and Human Services has issued fraud alters, clarifying that the routine waiver of co-payments and deductibles under Medicare and Medicaid constitutes fraud and may violate the Federal Anti-Kickback Statute. OIG Special Fraud Alert, reprinted in 59 Fed. Reg. 65372 (December 19, 1994) (available at https:/oighhs.gov/fraud/docs/ alertsandbulletins/121994.html. The OIG reasoned that the beneficiary would be improperly induced to receive unnecessary items or services if there was no amount owed by the patient, in turn increasing costs to the Medicare and Medicaid programs.

130. A number of States have enacted direct prohibitions related to a healthcare provider's waiver of co-payments and deductibles obligated in the insurance policy contract. *See e.g.,* Colorado (Colo. Rev. Stat. Ann. § 18-13-119(3) (West 2013)) (Colorado's civil statute prohibits the regular business practice of submitting a claim with the prior understanding or agreement to waive the copayment or deductible, or accept the amount the insurer covers as payment in full for serviced rendered); Florida (Fla. Admin. Code Ann. 690-153.003)

6 This interpretation was corroborated in an OIG Advisory Opinion in 1997 with the finding that the Medicare complementary coverage by an ASC would constitute grounds for sanctions under section 231(h) of HIPPA (42 U.S.C. §1320a-7(a)(5) or under Section 1128B(b) (relating to payment of kickbacks) under the Social Security Act (42 U.S.C. §§ 1320a-7b(b) and 1320a-7b(7)) (http:/oig.hhs/frauddocs/advisoryopinions 1997/97-4.pdf).

(Florida's criminal statute prohibits the knowing presentment or preparation of a claim containing materially false information or omissions); (Fla. Stat. Ann. § 817.234 (7)(a) (West 2013) (Florida's insurance fraud statute prohibits any service provider, other than a hospital, from billing amounts as the provider's usual and customary charge if the provider has agreed with the insured or intends "to accept less for the health care services rendered than is reflected on the claim form" or "has agreed with the insured or intends to waive deductibles or copayments, or does not for any other reason intend to collect the total amount of such charge."); Georgia (Ga. Code Ann. § 43-1-19.1(a) (2013)) (Georgia's civil statute makes it "a deceptive or misleading practice for any person duly licensed and authorized to provide any type of health care services to advertise, as an inducement to attract patients, the waiver of a deductible or copayment required to be made to such person under the patient's health insurance policy or plan."); Illinois (Ill. Compo Stat. 60/27 (2013)) (The Illinois Medical Practice Act of 1987 makes it unlawful for any licensed per- son (physician or chiropractor) to knowingly advertise acceptance of the amount the third party payor covers as payment in full for services rendered by assignment, if the effect is to give the impression of eliminating the need of payment by the patient of any required copayment or deductible applicable in the patient's health benefit plan).

131. Relator and other billers and collectors have been instructed for years to routinely write-off small deductibles and co-insurance payments. Attached as Exhibit "S" is an email exchange from March 2013 where Relator questioned Elizabeth Adams, Defendants' Location Director in Northern Virginia, whether she could write off a co-insurance amount for a Medicaid patient and evidence when that PSA routinely writes off such deductible and co-payments. In the March 28, 2013 email from Elizabeth Adams, she confirms to Relator that it is, "Our [PSA] policy is that if the patient has Medicaid we do not bill the parent for this co-insurance.

COUNT I

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (Presenting False Claims)

132. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

133. This is a claim on behalf of the United States under the False Claims Act, 31 U.S.C. §§ 3729-33, as amended.

134. The Plaintiff/Relator has standing to maintain this action by virtue of 31 U.S.C. § 3730(b).

135. By virtue of the acts described above and Defendants' deceptive and fraudulent actions, Defendants knowingly presented false or fraudulent claims for

payment, or knowingly caused false or fraudulent claims for payment to be presented, to officials of the United States Government in violation of 31 U.S.C. § 3729(a)(1), as amended.

136. The false claims for payment presented or caused to be presented by Defendants include all claims for reimbursement from the Government since the inception of the scheme described herein.

137. By virtue of the false claims presented or caused to by Defendants, the United States has suffered actual damages and is entitled to recover three times the amount by which it is damages, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT II

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (False Records or Statements)

138. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

139. This is a claim on behalf of the United States under the False Claims Act, 31 U.S.C. §§ 3729-33, as amended.

140. The Plaintiff/Relator has standing to maintain this action by virtue of 31 U.S.C. § 3730(b).

141. By virtue of the acts described above and Defendants' use of, or activities causing to be used, false records and statements to get false and fraudulent claims paid and approved by the Government, Defendants caused to be made or used false records or statements to get false or fraudulent claims paid or approved by an agency of the United States Government, in violation of 31 U.S.C. § 3729(a)(2).

142. By virtue of, and as a result of, the false records and statements used to get false claims paid by the Government, the United States has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,000 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT III

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (Presenting False Claims)

143. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

144. This is a claim under the Georgia State False Medicaid Claims Act, Georgia Code § 49-4-168.1, *et seq*.

145. The Plaintiff/Relator has standing to maintain this action by virtue of the Georgia State False Medicaid Claims Act, Georgia Code § 49-4-168.1, *et seq*.

146. By virtue of the acts described above and Defendants' deceptive and fraudulent actions, Defendants knowingly presented false or fraudulent claims for payment or knowingly caused false or fraudulent claims for payment to be presented, to officials to the State of Georgia in violation of the Georgia State False Medicaid Claims Act.

147. The false claims for payment presented or caused to be presented by Defendants include all claims for reimbursement from the State of Georgia since the inception of the scheme described herein.

148. By virtue of the false claims presented or caused to be presented by Defendants, the State of Georgia has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT IV

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (False Records or Statements)

149. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

150. This is a claim under the Georgia State False Medicaid Claims Act, Georgia Code § 49-4-168.1, *et seq*.

151. The Plaintiff/Relator has standing to maintain this action by virtue of the Georgia State False Medicaid Claims Act, Georgia Code § 49-4-168.1, *et seq*.

152. By virtue of the acts described above and Defendants' use of, or activities causing to be used, false records and statements to get false and fraudulent claims paid and approved by the State of Georgia, Defendants caused to be made or used false records or statements to get false and fraudulent claims paid or approved by an agency of the State of Georgia, in violation of the Georgia State False Medicaid Claims Act.

153. By virtue of, and as a result of, the false records and statements used to get false claims by the State of Georgia, the State of Georgia suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT V

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (Presenting False Claims)

154. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

155. This is a claim under the California False Claims Act, (Gov. Code § 12650, *et seq*.).

156. The Plaintiff/Relator has standing to maintain this action by virtue of the California False Claims Act (Gov. Code § 12650, *et seq.*).

157. By virtue of the acts described above and Defendants' deceptive and fraudulent actions, Defendants knowingly presented false or fraudulent claims for payment or knowingly caused false or fraudulent claims for payment to be presented, to officials to the State of California in violation of the California False Claims Act.

158. The false claims for payment presented or caused to be presented by Defendants include all claims for reimbursement from the State of California since the inception of the scheme described herein.

159. By virtue of the false claims presented or caused to be presented by Defendants, the State of California has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT VI

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (False Records or Statements)

160. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

161. This is a claim under the California False Claims Act (Gov. Code § 12650, *et seq.*).

162. The Plaintiff/Relator has standing to maintain this action by virtue of the California False Claims Act (Gov. Code § 12650, *et seq.*).

163. By virtue of the acts described above and Defendants' use of, or activities causing to be used, false records and statements to get false and fraudulent claims paid and approved by the State of California, Defendants caused to be made or used false records or statements to get false and fraudulent claims paid or approved by an agency of the State of California, in violation of the California False Claims Act.

164. By virtue of, and as a result of, the false records and statements used to get false claims by the State of California, the State of California suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT VII

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (Presenting False Claims)

165. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

166. This is a claim under the Colorado Medicaid False Claims Act, (Colo. Rev. State. 25.5-4-303.5, *et seq.*).

167. The Plaintiff/Relator has standing to maintain this action by virtue of the Colorado Medicaid False Claims Act (Colo. Rev. State. 25.5-4-303.5, *et seq.*).

168. By virtue of the acts described above and Defendants' deceptive and fraudulent actions, Defendants knowingly presented false or fraudulent claims for payment or knowingly caused false or fraudulent claims for payment to be presented, to officials to the State of Colorado in violation of the Colorado Medicaid False Claims Act.

169. The false claims for payment presented or caused to be presented by Defendants include all claims for reimbursement from the State of Colorado since the inception of the scheme described herein.

170. By virtue of the false claims presented or caused to be presented by Defendants, the State of Colorado has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,000 and not more than $10,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT VIII

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (False Records or Statements)

171. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

172. This is a claim under the Colorado Medicaid False Claims Act (Colo. Rev. State. 25.5-4-303.5, *et seq.*).

173. The Plaintiff/Relator has standing to maintain this action by virtue of the Colorado Medicaid False Claims Act (Colo. Rev. State. 25.5-4-303.5, *et seq.*).

174. By virtue of the acts described above and Defendants' use of, or activities causing to be used, false records and statements to get false and fraudulent claims paid and approved by the State of Colorado, Defendants caused to be made or used false records or statements to get false and fraudulent claims paid or approved by an agency of the State of Colorado, in violation of the Colorado Medicaid False Claims Act.

175. By virtue of, and as a result of, the false records and statements used to get false claims by the State of Colorado, the State of Colorado suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,000 and not more than $10,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT IX

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (Presenting False Claims)

176. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

177. This is a claim under the Connecticut False Claims Act for Medical Assistance Programs (Conn. Gen. Stat. § 17b-301(a), *et seq.*)

178. The Plaintiff/Relator has standing to maintain this action by virtue of the Connecticut False Claims Act for Medical Assistance Programs (Conn. Gen. Stat. § 17b-301(a), *et seq.*)

179. By virtue of the acts described above and Defendants' deceptive and fraudulent actions, Defendants knowingly presented false or fraudulent claims for payment or knowingly caused false or fraudulent claims for payment to be presented, to officials to the State of Connecticut in violation of the Connecticut False Claims Act for Medical Assistance Programs.

180. The false claims for payment presented or caused to be presented by Defendants include all claims for reimbursement from the State of Connecticut since the inception of the scheme described herein.

181. By virtue of the false claims presented or caused to be presented by Defendants, the State of Connecticut has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,000 and not more than $10,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT X

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (False Records or Statements)

182. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

183. This is a claim under the Connecticut False Claims Act for Medical Assistance Programs (Conn. Gen. Stat. § 17b-301(a), *et seq.*).

184. The Plaintiff/Relator has standing to maintain this action by virtue of the Connecticut False Claims Act for Medical Assistance Programs (Conn. Gen. Stat. § 17b-301(a), *et seq.*).

185. By virtue of the acts described above and Defendants' use of, or activities causing to be used, false records and statements to get false and fraudulent claims paid and approved by the State of Connecticut, Defendants caused to be made or used false records or statements to get false and fraudulent claims paid or approved by an agency of the State of Connecticut, in violation of the Connecticut False Claims Act for Medical Assistance Programs.

186. By virtue of, and as a result of, the false records and statements used to get false claims by the State of Connecticut, the State of Connecticut suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,000 and not more than

$10,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XI

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (Presenting False Claims)

187. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

188. This is a claim under the Florida False Claims Act, (Fla. Stat. Ann § 68.081, *et seq*.

189. The Plaintiff/Relator has standing to maintain this action by virtue of the Florida False Claims Act, (Fla. Stat. Ann § 68.081, *et seq*.).

190. By virtue of the acts described above and Defendants' deceptive and fraudulent actions, Defendants knowingly presented false or fraudulent claims for payment or knowingly caused false or fraudulent claims for payment to be presented, to officials to the State of Florida in violation of the Florida False Claims Act.

191. The false claims for payment presented or caused to be presented by Defendants include all claims for reimbursement from the State of Florida since the inception of the scheme described herein.

192. By virtue of the false claims presented or caused to be presented by Defendants, the State of Florida has suffered actual damages and is entitled to

recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XII

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (False Records or Statements)

193. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

194. This is a claim under the Florida False Claims Act (Fla. Stat. Ann § 68.081, *et seq.*).

195. The Plaintiff/Relator has standing to maintain this action by virtue of the Florida False Claims Act (Fla. Stat. Ann § 68.081, *et seq.*).

196. By virtue of the acts described above and Defendants' use of, or activities causing to be used, false records and statements to get false and fraudulent claims paid and approved by the State of Florida, Defendants caused to be made or used false records or statements to get false and fraudulent claims paid or approved by an agency of the State of Florida, in violation of the Florida False Claims Act.

197. By virtue of, and as a result of, the false records and statements used to get false claims by the State of Florida, the State of Florida suffered actual damages and is entitled to recover three times the amount by which it is damaged,

plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XIII

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (Presenting False Claims)

198. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

199. This is a claim under the Illinois Whistleblower Reward and Protection Act, 740 ILCS 175/1, *et seq*.

200. The Plaintiff/Relator has standing to maintain this action by virtue of the Illinois Whistleblower Reward and Protection Act, 740 ILCS 175/1, *et seq*.

201. By virtue of the acts described above and Defendants' deceptive and fraudulent actions, Defendants knowingly presented false or fraudulent claims for payment or knowingly caused false or fraudulent claims for payment to be presented, to officials to the State of Illinois in violation of the Illinois Whistleblower Reward and Protection Act.

202. The false claims for payment presented or caused to be presented by Defendants include all claims for reimbursement from the State of Illinois since the inception of the scheme described herein.

203. By virtue of the false claims presented or caused to be presented by Defendants, the State of Illinois has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,000 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XIV

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (False Records or Statements)

204. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

205. This is a claim under the Illinois Whistleblower Reward and Protection Act, 740 ILCS 175/1, *et seq*.

206. The Plaintiff/Relator has standing to maintain this action by virtue of the Illinois Whistleblower Reward and Protection Act, 740 ILCS 175/1, *et seq*.

207. By virtue of the acts described above and Defendants' use of, or activities causing to be used, false records and statements to get false and fraudulent claims paid and approved by the State of Illinois, Defendants caused to be made or used false records or statements to get false and fraudulent claims paid or approved by an agency of the State of Illinois, in violation of the Illinois Whistleblower Reward and Protection Act.

208. By virtue of, and as a result of, the false records and statements used to get false claims by the State Illinois, the State of Illinois suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,000 and not more than $10,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XV

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (Presenting False Claims)

209. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

210. This is a claim under the Louisiana False Claims Act/Medical Assistance Programs Integrity Law (LSA R.S. 46.437.1, *et seq.*).

211. The Plaintiff/Relator has standing to maintain this action by virtue of the Louisiana False Claims Act/Medical Assistance Programs Integrity (LSA R.S. 46.437.1, *et seq.*).

212. By virtue of the acts described above and Defendants' deceptive and fraudulent actions, Defendants knowingly presented false or fraudulent claims for payment or knowingly caused false or fraudulent claims for payment to be presented, to officials to the State of Louisiana in violation of the Louisiana False Claims Act/Medical Assistance Programs Integrity Law.

213. The false claims for payment presented or caused to be presented by Defendants include all claims for reimbursement from the State of Louisiana since the inception of the scheme described herein.

214. By virtue of the false claims presented or caused to be presented by Defendants, the State of Louisiana has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties not to exceed $10,000 of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XVI

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (False Records or Statements)

215. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

216. This is a claim under the Louisiana False Claims Act/Medical Assistance Programs Integrity Law (LSA R.S. 46.437.1, *et seq.*).

217. The Plaintiff/Relator has standing to maintain this action by virtue of the Louisiana False Claims Act/Medical Assistance Programs Integrity Law (LSA R.S. 46.437.1, *et seq.*).

218. By virtue of the acts described above and Defendants' use of, or activities causing to be used, false records and statements to get false and fraudulent claims paid and approved by the State of Louisiana, Defendants caused

to be made or used false records or statements to get false and fraudulent claims paid or approved by an agency of the State of Louisiana, in violation of the Louisiana False Claims Act/Medical Assistance Programs Integrity Law.

219. By virtue of, and as a result of, the false records and statements used to get false claims by the State of Louisiana, the State of Louisiana suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties not to exceed $10,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XVII

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (Presenting False Claims)

220. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

221. This is a claim under the Massachusetts False Claims Act, (Mass. Gen. Laws § 5A, *et seq*.).

222. The Plaintiff/Relator has standing to maintain this action by virtue of the Massachusetts False Claims Act, (Mass. Gen. Laws § 5A, *et seq*.).

223. By virtue of the acts described above and Defendants' deceptive and fraudulent actions, Defendants knowingly presented false or fraudulent claims for payment or knowingly caused false or fraudulent claims for payment to be

presented, to officials to the State of Massachusetts in violation of the Massachusetts False Claims Act.

224. The false claims for payment presented or caused to be presented by Defendants include all claims for reimbursement from the State of Massachusetts since the inception of the scheme described herein.

225. By virtue of the false claims presented or caused to be presented by Defendants, the State of Massachusetts has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,000 and not more than $10,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XVIII

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (False Records or Statements)

226. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

227. This is a claim under the Massachusetts False Claims Act, (Mass. Gen. Laws § 5A, *et seq.*).

228. The Plaintiff/Relator has standing to maintain this action by virtue of the Massachusetts False Claims Act, (Mass. Gen. Laws § 5A, *et seq.*).

229. By virtue of the acts described above and Defendants' use of, or activities causing to be used, false records and statements to get false and fraudulent claims paid and approved by the State of Massachusetts, Defendants caused to be made or used false records or statements to get false and fraudulent claims paid or approved by an agency of the State of Massachusetts, in violation of the Massachusetts False Claims Act.

230. By virtue of, and as a result of, the false records and statements used to get false claims by the State of Massachusetts, the State of Massachusetts suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,000 and not more than $10,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XIX

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (Presenting False Claims)

231. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

232. This is a claim under the New Jersey False Claims Act (NJ ST. 2A:32C-1, *et seq.*).

233. The Plaintiff/Relator has standing to maintain this action by virtue of the New Jersey False Claims Act, (NJ ST. 2A:32C-1, *et seq.*).

234. By virtue of the acts described above and Defendants' deceptive and fraudulent actions, Defendants knowingly presented false or fraudulent claims for payment or knowingly caused false or fraudulent claims for payment to be presented, to officials to the State of New Jersey in violation of the New Jersey False Claims Act, (NJ St 2A:32C-1, *et seq.*).

235. The false claims for payment presented or caused to be presented by Defendants include all claims for reimbursement from the State of New Jersey since the inception of the scheme described herein.

236. By virtue of the false claims presented or caused to be presented by Defendants, the State of New Jersey has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XX

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (False Records or Statements)

237. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

238. This is a claim under the New Jersey False Claims Act, (NJ ST 2A:32C-1, *et seq.*).

239. The Plaintiff/Relator has standing to maintain this action by virtue of the New Jersey False Claims Act, (NJ ST. 2A:32C-1, *et seq.*).

240. By virtue of the acts described above and Defendants' use of, or activities causing to be used, false records and statements to get false and fraudulent claims paid and approved by the State of New Jersey, Defendants caused to be made or used false records or statements to get false and fraudulent claims paid or approved by an agency of the State of New Jersey, in violation of the New Jersey False Claims Act.

241. By virtue of, and as a result of, the false records and statements used to get false claims by the State of New Jersey, the State of New Jersey suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XXI

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (Presenting False Claims)

242. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

243. This is a claim under the New York False Claims Act, (NY STATE FIN § 187, *et seq.*).

244. The Plaintiff/Relator has standing to maintain this action by virtue of the New York Finance Law, (NY STATE FIN § 187, *et seq.*).

245. By virtue of the acts described above with respect to Defendants' deceptive and fraudulent actions, Defendants knowingly presented false or fraudulent claims for payment, or knowingly caused false or fraudulent claims for payment to be presented, to officials to the State of New York in violation of the New York False Claims Act.

246. The false claims for payment presented or caused to be presented by Defendants include all claims for reimbursement from the State of New York since the inception of the scheme described herein.

247. By virtue of the false claims presented or caused to be presented by Defendants, the State of New York has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $6,000 and not more than $12,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XXII

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (False Records or Statements)

248. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

249. This is a claim on behalf of the State of New York under the New York False Claims Act, New York Finance Law Article XIII, (NY STATE FIN § 187, *et seq.*).

250. The Plaintiff/Relator has standing to maintain this action by virtue of the York False Claims Act, New York Finance Law Article XIII, (NY STATE FIN § 187, *et seq.*).

251. By virtue of the acts described above and Defendants' use of, or activities causing to be used, false records and statements to get false and fraudulent claims paid and approved by the State of New York, Defendants caused to be made or used false records or statements to get false and fraudulent claims paid or approved by an agency of the State of New York, in violation of the New York False Claims Act.

252. By virtue of, and as a result of, the false records and statements used to get false claims by the Government, the State of New York suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $6,000 and not more than $12,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XXIII

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (Presenting False Claims)

253. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

254. This is a claim under the North Carolina False Claims Act (N.C. G.S.A. § 108A-70-10, *et seq.*).

255. The Plaintiff/Relator has standing to maintain this action by virtue of the North Carolina False Claims Act, (N.C. G.S.A. § 108A-70-10, *et seq.*).

256. By virtue of the acts described above and Defendants' deceptive and fraudulent actions, Defendants knowingly presented false or fraudulent claims for payment or knowingly caused false or fraudulent claims for payment to be presented, to officials to the State of North Carolina in violation of the North Carolina False Claims Act.

257. The false claims for payment presented or caused to be presented by Defendants include all claims for reimbursement from the State of North Carolina since the inception of the scheme described herein.

258. By virtue of the false claims presented or caused to be presented by Defendants, the State of North Carolina has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XXIV

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (False Records or Statements)

259. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

260. This is a claim under the North Carolina False Claims Act, (N.C. G.S.A. § 108A-70-10, *et seq.*).

261. The Plaintiff/Relator has standing to maintain this action by virtue of the North Carolina False Claims Act, (N.C. G.S.A. § 108A-70-10, *et seq.*).

262. By virtue of the acts described above and Defendants' use of, or activities causing to be used, false records and statements to get false and fraudulent claims paid and approved by the State of North Carolina, Defendants caused to be made or used false records or statements to get false and fraudulent claims paid or approved by an agency of the State of North Carolina, in violation of the North Carolina False Claims Act, (N.C. G.S.A. § 108A-70-10, *et seq.*).

263. By virtue of, and as a result of, the false records and statements used to get false claims by the State of North Carolina, the State of North Carolina suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XXV

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (Presenting False Claims)

264. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

265. This is a claim under the Texas Medicaid Fraud Prevention Act, (TEX. HUM. RES. Code § 36.001, *et seq.*).

266. The Plaintiff/Relator has standing to maintain this action by virtue of the Texas Medicaid Fraud Prevention Act, (TEX. HUM. RES. Code § 36.001, *et seq.* and Tex. Gov't Code Ann. § 531.101, *et seq.*).

267. By virtue of the acts described above and Defendants' deceptive and fraudulent actions, Defendants knowingly presented false or fraudulent claims for payment or knowingly caused false or fraudulent claims for payment to be presented, to officials to the State of Texas in violation of the Texas Medicaid Fraud Prevention Act.

268. The false claims for payment presented or caused to be presented by Defendants include all claims for reimbursement from the State of Texas since the inception of the scheme described herein.

269. By virtue of the false claims presented or caused to be presented by Defendants, the State of Texas has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties

of between $5,000 and $10,000 for each violation of the Act, escalated to $15,000 if the violation results in harm to an elderly person for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XXVI

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (False Records or Statements)

270. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

271. This is a claim under Texas Medicaid Fraud Prevention Act, (TEX. HUM. RES. Code § 36.001, *et seq*. and Tex. Gov't Code Ann. § 531.101, *et seq*.).

272. The Plaintiff/Relator has standing to maintain this action by virtue of the Texas Medicaid Fraud Prevention Act, (TEX. HUM. RES. Code § 36.001, *et seq*.).

273. By virtue of the acts described above and Defendants' use of, or activities causing to be used, false records and statements to get false and fraudulent claims paid and approved by the State of Texas, Defendants caused to be made or used false records or statements to get false and fraudulent claims paid or approved by an agency of the State of Texas, in violation of the Texas Medicaid Fraud Prevention Act.

274. By virtue of, and as a result of, the false records and statements used to get false claims by the State of Texas, the State of Texas suffered actual

damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of between $5,000 and $10,000 for each violation of the Act, escalated to $15,000 if the violation results in harm to an elderly person for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XXVII

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (Presenting False Claims)

275. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

276. This is a claim under the Virginia Fraud Against Taxpayers Act, §8.01 – 216.1.

277. The Plaintiff/Relator has standing to maintain this action by virtue of the Virginia Fraud Against Taxpayers Act, §8.01 – 216.1.

278. By virtue of the acts described above and Defendants' deceptive and fraudulent actions, Defendants knowingly presented false or fraudulent claims for payment or knowingly caused false or fraudulent claims for payment to be presented, to officials to the State of Virginia in violation of the Virginia Fraud Against Taxpayers Act.

279. The false claims for payment presented or caused to be presented by Defendants include all claims for reimbursement from the State of Virginia since the inception of the scheme described herein.

280. By virtue of the false claims presented or caused to be presented by Defendants, the State of Virginia has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XXVIII

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (False Records or Statements)

281. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

282. This is a claim under the Virginia Fraud Against Taxpayers Act, §8.01 – 216.1.

283. The Plaintiff/Relator has standing to maintain this action by virtue of the Virginia Fraud Against Taxpayers Act, §8.01 – 216.1.

284. By virtue of the acts described above and Defendants' use of, or activities causing to be used, false records and statements to get false and fraudulent claims paid and approved by the State of Virginia, Defendants caused to be made or used false records or statements to get false and fraudulent claims paid

or approved by an agency of the State of Virginia, in violation of the Virginia Fraud Against Taxpayers Act, §8.01 – 216.1.

285. By virtue of, and as a result of, the false records and statements used to get false claims by the State of Virginia, the State of Virginia suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XXIX

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (Presenting False Claims)

286. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

287. This is a claim under the Washington State Medicaid Fraud False Claims Act, (RCW 74.66.005, *et seq.*).

288. The Plaintiff/Relator has standing to maintain this action by virtue of the Washington State Medicaid Fraud False Claims Act, (RCW 74.66.005, *et seq.*).

289. By virtue of the acts described above and Defendants' deceptive and fraudulent actions, Defendants knowingly presented false or fraudulent claims for payment or knowingly caused false or fraudulent claims for payment to be

presented, to officials to the State of Washington in violation of the Washington State Medicaid Fraud False Claims Act.

290. The false claims for payment presented or caused to be presented by Defendants include all claims for reimbursement from the State of Washington since the inception of the scheme described herein.

291. By virtue of the false claims presented or caused to be presented by Defendants, the State of Washington has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XXX

Claim By and on Behalf of the United States under the False Claims Act Relating to Defendants' above-referenced conduct (False Records or Statements)

292. Plaintiff realleges and incorporates by reference paragraph "1" through "131" as though fully set forth herein.

293. This is a claim under the Washington State Medicaid Fraud False Claims Act, (RCW 74.66.005, *et seq.*).

294. The Plaintiff/Relator has standing to maintain this action by virtue of the Washington State Medicaid Fraud False Claims Act, (RCW 74.66.005, *et seq.*).

295. By virtue of the acts described above and Defendants' use of, or activities causing to be used, false records and statements to get false and

fraudulent claims paid and approved by the State of Washington, Defendants caused to be made or used false records or statements to get false and fraudulent claims paid or approved by an agency of the State of Washington, in violation of the Washington State Medicaid Fraud False Claims Act, (RCW 74.66.005, *et seq.*).

296. By virtue of, and as a result of, the false records and statements used to get false claims by the State of Washington, the State of Washington suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XXXI
False Claims Act
31 U.S.C. § 3730(h)
(Defendant PSA)

297. Plaintiff realleges and incorporates by references in paragraphs "1" through "131" as though fully set forth herein.

298. This is a claim for damages under the False Claims Act, 31 U.S.C. § 3730(h).

299. From October 2011 through at least January 2013, Relator reported her good faith belief that Defendants may be violating the False Claims Act as set forth herein to Defendant PS's employees and management officials.

300. In April 2012, Relator's employment with Defendant PSA was reduced from "Billing Specialist" to "Collector."

301. In April 2013, Relator's salary threatened to be cut by approximately 25%. The demotion of Relator's employment position and salary and subsequent treatment by Defendants of Realtor during and after her accident and disability at the Defendants' offices as described herein violates the provisions of 31 U.S.C. § 3730(h) and Various State Acts prohibiting discrimination by employers against employees who investigate and/or report violations of the False Claims Act and various state false claims act, anti-retaliation provisions and PSA's internal Compliance Policies.

302. As a direct and proximate result of the demotion of Relator's employment, Relator has lost substantial benefits of employment including actual and future wage loss and benefits.

303. As a direct and proximate result of the demotion of Relator's employment, Relator has sustained, among other things, emotional distress, anxiety, heart problems and embarrassment.

304. As a direct and proximate result of Defendant PSA's conduct, Relator is entitled to recover her attorney's fees and costs incurred herein.

305. Defendant PSA's acts against Relator were willful, wanton and malicious and violated Relator's federally-protected rights and Relator is entitled to recover punitive and exemplary damages in an amount to be proven at trial.

PRAYER FOR RELIEF

WHEREFORE, the United States and the states of Georgia, California, Colorado, Connecticut, Florida, Illinois, Louisiana, Massachusetts, New Jersey, New York, North Carolina, Texas, Virginia and Washington demand and pray that judgment to be entered in their favor as follows against Defendants jointly and severally:

1. On Counts I and II, under the False Claims Act, against Defendants for treble the amount of the United States' actual damages (including investigative costs), plus civil penalties as are allowable by law for each false claim or record and for all costs of this civil action;

2. On Counts III and IV, under the Georgia State False Medicaid Claims Act, against Defendants for treble the amount of actual damages suffered by the State of Georgia (including investigative costs), plus civil penalties as are allowable by law for each false claim or record and for all costs of this civil action;

3. On Counts V and VI, under the California False Claims Act, against Defendants for treble the amount of the State of California actual damages

(including investigative costs), plus civil penalties as are allowable by law for each false claim or record and for all costs of this civil action;

4. On Counts VII and VIII, under the Colorado Medicaid False Claims Act, against Defendants for treble the amount of the State of Colorado actual damages (including investigative costs), plus civil penalties as are allowable by law for each false claim or record and for all costs of this civil action;

5. On Counts IX and X, under the Connecticut False Claims Act for Medical Assistance Programs, against Defendants for treble the amount of actual damages suffered by the State of Connecticut (including investigative costs), plus civil penalties as are allowable by law for each false claim or record and for all costs of this civil action;

6. On Counts XI and XII, under the Florida False Claims Act, against Defendants for treble the amount of the State of Florida's actual damages (including investigative costs), plus civil penalties as are allowable by law for each false claim or record and for all costs of this civil action;

7. On Counts XIII and XIV, under the Illinois Whistleblower Reward and Protection, against Defendants for treble the amount of actual damages suffered by the State of Illinois (including investigative costs), plus civil penalties as are allowable by law for each false claim or record and for all costs of this civil action;

8. On Counts XV and XVI, under the Louisiana False Claims Act/Medical Assistance Programs, against Defendants for treble the amount of the State of Louisiana actual damages (including investigative costs), plus civil penalties as are allowable by law for each false claim or record and for all costs of this civil action;

9. On Counts XVII and XVIII, under the Massachusetts False Claims Act, against Defendants for treble the amount of actual damages suffered by the State of Massachusetts (including investigative costs), plus civil penalties as are allowable by law for each false claim or record and for all costs of this civil action;

10. On Counts XIX and XX, under the New Jersey False Claims Act, against Defendants for treble the amount of actual damages suffered by the State of New Jersey (including investigative costs), plus civil penalties as are allowable by law for each false claim or record and for all costs of this civil action;

11. On Counts XXI and XXII New York False Claims Act, against Defendants for treble the amount of the State of New York's actual damages (including investigative costs), plus civil penalties as are allowable by law for each false claim or record and for all costs of this civil action;

12. On Counts XXIII and XXIV, under the North Carolina False Claims Act, against Defendants for treble the amount of actual damages suffered by the

State of North Carolina (including investigative costs), plus civil penalties as are allowable by law for each false claim or record and for all costs of this civil action;

13. On Counts XXV and XXVI, under the Texas Medicaid Fraud Prevention Act, against Defendants for treble the amount of actual damages suffered by the State of Texas (including investigative costs), plus civil penalties as are allowable by law for each false claim or record and for all costs of this civil action and as otherwise authorized under Tex. Gov't Code Ann. §531.101, *et seq.*

14. On Counts XXVII and XXVIII, under the Virginia Fraud Against Taxpayers Act, against Defendants for treble the amount of actual damages suffered by the State of Virginia (including investigative costs), plus civil penalties as are allowable by law for each false claim or record and for all costs of this civil action;

15. On Counts XXIX and XXX, under the Washington State Medicaid Fraud False Claims Act, against Defendants for treble the amount of actual damages suffered by the State of Washington (including investigative costs), plus civil penalties as are allowable by law for each false claim or record and for all costs of this civil action;

16. For all costs of this civil action; and

17. For such other and further relief as the Court deems just and equitable.

WHEREFORE, Relator demands and prays that judgment be entered in her favor:

1. On Counts I and II, under the False Claims Act, for a percentage of all civil penalties and damages obtained from Defendants pursuant to 31 U.S.C. § 3730, reasonable attorney's fees and all costs incurred against Defendants;

2. On Counts III and IV, under the Georgia State False Medicaid Claims Act, for a percentage of all civil penalties and damages from Defendants pursuant to the Georgia State False Medicaid Claims Act, reasonable attorney's fees and all costs incurred against Defendants;

3. On Counts V and VI, under the California False Claims Act, for a percentage of all civil penalties and damages from Defendants pursuant to the California False Claims Act, reasonable attorney's fees and all costs incurred against Defendants;

4. On Counts VII and VIII, under the Colorado Medicaid False Medicaid Claims Act, for a percentage of all civil penalties and damages from Defendants pursuant to the Colorado State False Medicaid Claims Act, reasonable attorney's fees and all costs incurred against Defendants;

5. On Counts IX and X, under the Connecticut False Claims Act for Medical Assistance Programs, for a percentage of all civil penalties and damages from Defendants pursuant to the Connecticut False Claims Act for Medical

Assistance Programs, reasonable attorney's fees and all costs incurred against Defendants;

6. On Counts XI and XII, under the Florida False Claims Act, for a percentage of all civil penalties and damages from Defendants pursuant to the New Florida False Claims Act, reasonable attorney's fees and all costs incurred against Defendants;

7. On Counts XIII and XIV, under the Illinois Whistleblower Reward and Protection Act, for a percentage of all civil penalties and damages from Defendants pursuant to the Illinois Whistleblower Reward and Protection Act, reasonable attorney's fees and all costs incurred against Defendants;

8. On Counts XV and XVI, under the Louisiana State False Claims Act/Medical Assistance Programs, for a percentage of all civil penalties and damages from Defendants pursuant to the Louisiana State False Claims Act/Medical Assistance Programs, reasonable attorney's fees and all costs incurred against Defendants;

9. On Counts XVII and XVIII, under the Massachusetts False Claims Act, Programs, for a percentage of all civil penalties and damages from Defendants pursuant to the Massachusetts False Claims Act, reasonable attorney's fees and all costs incurred against Defendants;

10. On Counts XIX and XX, under the New Jersey False Claims Act, for a percentage of all civil penalties and damages from Defendants pursuant to the New Jersey False Claims Act, reasonable attorney's fees and all costs incurred against Defendants;

11. On Counts XXI and XXII, under the New York False Claims Act, for a percentage of all civil penalties and damages from Defendants pursuant to the New York False Claims Act, reasonable attorney's fees and all costs incurred against Defendants;

12. On Counts XXIII and XXIV, under the North Carolina False Claims Act, for a percentage of all civil penalties and damages from Defendants pursuant to the North Carolina False Claims Act, reasonable attorney's fees and all costs incurred against Defendants;

13. On Counts XXV and XXVI, under the Texas Medicaid Fraud Prevention Act, for a percentage of all civil penalties and damages from Defendants pursuant to the Texas Medicaid Fraud Prevention Act, reasonable attorney's fees and all costs incurred against Defendants and was otherwise permitted under Tex. Gov't Code Ann. §531.101, *et seq.*);

14. On Counts XXVII and XXVIII, under the Virginia Fraud False Claims Act for Medical Assistance Programs, for a percentage of all civil penalties and damages from Defendants pursuant to the Connecticut False Claims Act for

Medical Assistance Programs, reasonable attorney's fees and all costs incurred against Defendants;

15. On Counts XXIX and XXX, under the Washington State Medicaid Fraud False Claims Act, for a percentage of all civil penalties and damages from Defendants pursuant to the Washington State Medicaid Fraud False Claims Act, reasonable attorney's fees and all costs incurred against Defendants;

16. Directing Defendant PSA to place Plaintiff/Relator in a position where she would have held but for Defendant PSA's discriminatory and retaliatory treatment of her and to make Plaintiff/Relator whole for all earnings and benefits she would have received but for Defendant PSA's discriminatory and retaliatory treatment including but not limited to wages (including front and back pay and interest thereon) and benefits and any and all other relief afforded under the whistleblower protections contained in 31 U.S.C. § 3730(h), Georgia Code §49-4-168.4 and the protection of employees from discrimination and retaliation under the aforementioned applicable State Acts.

17. That Plaintiff/Relator recover general compensatory damages in an amount to be proven at trial;

18. That Plaintiff/Relator recover punitive and exemplary damages in an amount to be proven at trial;

19. Plaintiff/Relator recover prejudgment and postjudgment interest; and

20. Such other relief as the Court deems just and proper.

Respectfully submitted this 11th day of December, 2013.

Raymond L. Moss
Lead Counsel
Admitted Pro Hac Vice
Georgia Bar No. 526569
rlmoss@mossgilmorelaw.com

MOSS & GILMORE LLP
3630 Peachtree Road
Suite 1025
Atlanta, Georgia 30326
Telephone No. (678) 381-8601
Facsimile No. (815) 364-0515
Email: rlmoss@mossgilmorelaw.com

EXHIBIT "A"

Sheila McCray

From: David Malloy
Sent: Friday, September 30, 2011 5:04 PM
To: Sheila McCray
Cc: Jonathan Solomon
Subject: RE: CREDIT REPORT.xlsx

Excellent work on this Sheila. In one week you have resolved 1/2 of our credit problem. Thanks!

David Malloy | Director, Shared Services | PSA Healthcare
310 Technology Parkway Norcross, GA 30092 | dmalloy@psahealthcare.com
o: 770-840-2441 | f: 770-840-2441 | m: 678-592-1700
psahealthcare

From: Sheila McCray
Sent: Friday, September 30, 2011 4:55 PM
To: David Malloy; Jonathan Solomon
Subject: CREDIT REPORT.xlsx

This is an update on the commercial insurances. For the patients that do not appear on this report there are many issues that will need to be resolved before moving forward.

Thanks,

Sheila

EXHIBIT "B"

fm My PSA w.h:

SUBJECT: Refunds
APPROVED BY: Governing Body
DATE EFFECTIVE: May 1, 1998
DATE REVISED: January 1, 2007
REVISION APPROVED BY: Governing Body
REVISED EFFECTIVE DATE: 1/1/07
MANUAL: Administrative

It is the policy of the Company to be aware of accounts with credit balances. Accounts with credit balances will be researched to determine the reason for the credit balance. If an overpayment has been made on the account, appropriate steps will be taken to refund the payer within a timely manner.

If a patient is not satisfied with the care and services provided and informs the Company within 24 hours, charges for those services will be adjusted or reduced if the complaint is reasonable and has been reviewed and approved by the Location Director. Refunds in excess of $ 3000.00 must be approved by the Operations Vice President. If the patient has already paid the Company, the appropriate monies will be refunded.

Medicare/Medicaid

It is the policy of the Company to have a process in place to arrange for the refund/recoup of all Medicare and Medicaid overpayments within 30 days of receipt.

All refunds and recoup are monitored by the Compliance Department and processed by the Account Receivables Department. For further information related to the applicability of the refund process, contact either the Compliance Officer or the Vice-President of Financial Assets.

All billing errors will be corrected as recognized by clients, PSA staff and the Reimbursement Department.

EXHIBIT "C"

Sheila McCray

From: Sonya Simpson
Sent: Friday, February 10, 2012 12:01 PM
To: Sheila McCray
Cc: David Malloy
Subject: RE: Credits

Sheila,
As we discussed yesterday and in today's meeting, please be sure we are testing one claim on those voids through the web portal for overpayments. Let me know if you have any questions.

Thank you!

-Sonya Simpson

psahealthcare

From: Sheila McCray
Sent: Friday, February 10, 2012 10:46 AM
To: David Malloy
Cc: Jonathan Solomon
Subject: Credits

David,

This is an update on my process. I have completed on average 360k in commercial adjustments and credits. All of the overpayments have been absorbed until further notice. All of the duplicate payments have been refunded of the 360k total. I am currently working on the Medicaid VOIDS through the portal for duplicate payments.

Thanks,

Sheila McCray CPC, RHIT
A/R Billing Specialist
SMcCray@psahealthcare.com
770/441-1580 Ext. 183

* work through portal if they keep money, so not continue to do voids.
* Did manual in person until they

EXHIBIT "D"

Sheila McCray

From: Jonathan Solomon
Sent: Friday, February 10, 2012 12:15 PM
To: Sonya Simpson; Sheila McCray
Cc: David Malloy
Subject: RE: Credits

Would it make more sense to actually call Medicaid first to make sure we know how this works? Also, can I get some feedback on what we are seeing (reasons) for the Medicaid credits.
Thanks,

Jonathan Solomon
Chief Corporate Development Officer
PSA Healthcare
Six Concourse Parkway, Suite # 1100
Atlanta, GA 30328
Phone: 770.840.2427
E-Fax: 770.840.2427
Email: jsolomon@psahealthcare.com

From: Sonya Simpson
Sent: Friday, February 10, 2012 12:01 PM
To: Sheila McCray
Cc: David Malloy
Subject: RE: Credits

Sheila,
As we discussed yesterday and in today's meeting, please be sure we are testing one claim on those voids through the web portal for overpayments. Let me know if you have any questions.

Thank you!

-Sonya Simpson

psahealthcare

From: Sheila McCray
Sent: Friday, February 10, 2012 10:46 AM
To: David Malloy
Cc: Jonathan Solomon
Subject: Credits

David,

This is an update on my process. I have completed on average 360k in commercial adjustments and credits. All of the overpayments have been absorbed until further notice. All of the duplicate payments have been refunded of the 360k total. I am currently working on the Medicaid VOIDS through the portal for duplicate payments.

Thanks,

Sheila McCray CPC, RHIT
A/R Billing Specialist
SMcCray@psahealthcare.com
770/441-1580 Ext. 183

EXHIBIT "E"

Sheila McCray

From: David Malloy
Sent: Friday, February 10, 2012 12:21 PM
To: Sonya Simpson
Cc: Sheila McCray; Jonathan Solomon
Subject: Re: Credits

That is part of the research that will do done as the claims are investigated. We choreographed the process out yesterday beginning to end. Sonya, in lieu of my absence, would you walk Jonathan through what we will do? Thanks

David

Sent from my iPhone

On Feb 10, 2012, at 12:15 PM, "Jonathan Solomon" <JSolomon@psahealthcare.com> wrote:

> Would it make more sense to actually call Medicaid first to make sure we know how this works? Also, can I get some feedback on what we are seeing (reasons) for the Medicaid credits.
> Thanks,
>
> **Jonathan Solomon**
> **Chief Corporate Development Officer**
> PSA Healthcare
> Six Concourse Parkway, Suite # 1100
> Atlanta, GA 30328
> *Phone: 770.840.2427*
> *E-Fax: 770.840.2427*
> *Email: jsolomon@psahealthcare.com*
>
>

From: Sonya Simpson
Sent: Friday, February 10, 2012 12:01 PM
To: Sheila McCray
Cc: David Malloy
Subject: RE: Credits

Sheila,
As we discussed yesterday and in today's meeting, please be sure we are testing one claim on those voids through the web portal for overpayments. Let me know if you have any questions.

Thank you!

-Sonya Simpson

<image001.gif>

From: Sheila McCray
Sent: Friday, February 10, 2012 10:46 AM
To: David Malloy
Cc: Jonathan Solomon
Subject: Credits

David,

This is an update on my process. I have completed on average 360k in commercial adjustments and credits. All of the overpayments have been absorbed until further notice. All of the duplicate payments have been refunded of the 360k total. I am currently working on the Medicaid VOIDS through the portal for duplicate payments.

Thanks,

Sheila McCray CPC, RHIT
A/R Billing Specialist
SMcCray@psahealthcare.com
770/441-1580 Ext. 183

EXHIBIT "F"

David Malloy

From: Jonathan Solomon
Sent: Tuesday, April 03, 2012 4:44 PM
To: Lori Moore; David Malloy
Cc: Opal Ferraro
Subject: RE: credit resolution process.xlsx

Jim, Opal and I decided:
Duplicates:

1) Those duplicates that are only Medicaid – give money back
2) Those duplicates that are only Commercial – we are going to set up a separate sub-ledger and we will move those claims to that ledger to get them off of the AR. Please keep the detail and the amount, but they should not show up on the AR to be worked.
3) Those duplicates that have both Medicaid and Commercial (there were only three) – give the money back to Medicaid and write in the commercial.

Please let me know if you have any questions.
Thanks,

Jonathan Solomon
Chief Corporate Development Officer
PSA Healthcare
Six Concourse Parkway, Suite # 1100
Atlanta, GA 30328
Phone: 770.840.2427
E-Fax: 770.840.2427
Email: jsolomon@psahealthcare.com

From: Lori Moore
Sent: Tuesday, April 03, 2012 12:54 PM
To: Jonathan Solomon; David Malloy
Subject: credit resolution process.xlsx

Here is the revised data, I have looked at adding the delete and rekey logic, but will try and do so by the end of the week.

EXHIBIT "G"

Sheila McCray

From: Sonya Simpson
Sent: Monday, December 10, 2012 10:21 AM
To: Sheila McCray
Subject: RE: Medicaid Claims over 365

You can leave the adjustments for now....we will circle back to those. Right now our focus is on the open A/R...unless the credits affects the debit balance.

-Sonya Simpson

psahealthcare

From: Sheila McCray
Sent: Monday, December 10, 2012 10:16 AM
To: Sonya Simpson
Cc: Sheila McCray
Subject: Medicaid Claims over 365

Good Morning Sonya,

I have claims that are over 365 for Medicaid. I can do the adjustment for the refund, but claims are considered untimely at this point. What would you like for me to do with those refunds/adjustments?

Thank you,

EXHIBIT "H"

Rollup = Billed

Claim # 3803729

From Dt	Thru Dt	Description	Qty Limits	Total Charges	Total Allowed	Balance	Total Adjustments	Adjusted Balance
02/02/09	(02/02/09	(LPN HOURLY/PDN(CAH NO M(	4.25	105.45	105.45	-7.03		
	2/10/09	Charge	91.93	MEDICAID (NY) CAH (TPL/EDI) <				
	3/6/09	Charge Amt Correction	-7.03	MEDICAID (NY) CAH (TPL/EDI) <			COR	
	1/31/13	Compliance Audit Adjustment	-7.03	MEDICAID (NY) CAH (TPL/EDI) <			COR	
	2/10/09	Rate Increase	27.58	MEDICAID (NY) CAH (TPL/EDI) <				
ELDP70556	3/6/09	Insurance Payment	-112.48	MEDICAID (NY) CAH (TPL/EDI) <				
02/03/09	(02/03/09	(LPN HOURLY/PDN(CAH NO M(	4.5	105.46	105.46	-21.09		
	2/10/09	Charge	97.34	MEDICAID (NY) CAH (TPL/EDI) <				
	1/31/13	Compliance Audit Adjustment	-21.09	MEDICAID (NY) CAH (TPL/EDI) <			COR	
	2/10/09	Rate Increase	29.21	MEDICAID (NY) CAH (TPL/EDI) <				
ELDP70556	3/6/09	Disallowed (Cash Credit)	-0.01	MEDICAID (NY) CAH (TPL/EDI) <				
ELDP70556	3/6/09	Insurance Payment	-126.54	MEDICAID (NY) CAH (TPL/EDI) <				
02/04/09	(02/04/09	(LPN HOURLY/PDN(CAH NO M(	4.5	105.46	105.46	-21.09		
	2/10/09	Charge	97.34	MEDICAID (NY) CAH (TPL/EDI) <				
	1/31/13	Compliance Audit Adjustment	-21.09	MEDICAID (NY) CAH (TPL/EDI) <			COR	
	2/10/09	Rate Increase	29.21	MEDICAID (NY) CAH (TPL/EDI) <				
ELDP70556	3/6/09	Disallowed (Cash Credit)	-0.01	MEDICAID (NY) CAH (TPL/EDI) <				
ELDP70556	3/6/09	Insurance Payment	-126.54	MEDICAID (NY) CAH (TPL/EDI) <				
02/05/09	(02/05/09	(LPN HOURLY/PDN(CAH NO M(	4.	77.33	77.33	-35.15		
	2/10/09	Charge	86.52	MEDICAID (NY) CAH (TPL/EDI) <				
	1/31/13	Compliance Audit Adjustment	-35.15	MEDICAID (NY) CAH (TPL/EDI) <			COR	
	2/10/09	Rate Increase	25.96	MEDICAID (NY) CAH (TPL/EDI) <				
ELDP70556	3/6/09	Insurance Payment	-112.48	MEDICAID (NY) CAH (TPL/EDI) <				
02/06/09	(02/06/09	(LPN HOURLY/PDN(CAH NO M(	3.25	63.28	63.28	-21.09		
	2/10/09	Charge	70.30	MEDICAID (NY) CAH (TPL/EDI) <				
	1/31/13	Compliance Audit Adjustment	-21.09	MEDICAID (NY) CAH (TPL/EDI) <			COR	
	3/6/09	Charge Amt Correction	-7.03	MEDICAID (NY) CAH (TPL/EDI) <			COR	
	2/10/09	Rate Increase	21.10	MEDICAID (NY) CAH (TPL/EDI) <				
ELDP70556	3/6/09	Disallowed (Cash Credit)	-0.01	MEDICAID (NY) CAH (TPL/EDI) <				
ELDP70556	3/6/09	Insurance Payment	-84.36	MEDICAID (NY) CAH (TPL/EDI) <				
02/07/09	(02/07/09	1 LPN HOURLY/PDN(CAH NO M(	4.	112.48	112.48	0.00		
	2/10/09	Charge	86.52	MEDICAID (NY) CAH (TPL/EDI) <				
	2/10/09	Rate Increase	25.96	MEDICAID (NY) CAH (TPL/EDI) <				
ELDP70556	3/6/09	Insurance Payment	-112.48	MEDICAID (NY) CAH (TPL/EDI) <				

Proof that Compliance Department Knows PSA is intentionally Keeping the money for 3 years in NY. Note only different rate increase. These should be the same!

Page 1 of 1	Claim Totals:	569.46	569.46	-105.45

Coverage . 1. MEDICAID (NY) CAH (TPL/EDI) <21 (C) 4. Guarantor

Claim #	Earliest From	Latest Thru Dt	Total Charges	Total Allowed	Balance	Curr Payor	Aging	Last Action	Last Action Dt	Review Dt
3797582	1/1/09	1/16/09	1,631.01	1,631.01	-161.73 *	1	1/21/09	Adjusted	1/31/13	1/31/13
3801717	1/26/09	1/31/09	773.31	773.31	-91.40	1	2/3/09	Adjusted	1/31/13	1/31/13
3803729	2/2/09	2/7/09	569.46	569.46	-105.45	1	2/10/09	Adjusted	1/31/13	1/31/13
3805941	2/9/09	2/14/09	1,110.73	1,110.73	-28.14	1	2/17/09	Adjusted	1/31/13	1/31/13
3808188	2/16/09	2/21/09	555.39	555.39	-49.22	1	2/24/09	Adjusted	1/31/13	1/31/13
3810645	2/23/09	2/28/09	710.02	710.02	-77.35	1	3/3/09	Adjusted	1/31/13	1/31/13
3812761	3/2/09	3/7/09	576.48	576.48	-77.34	1	3/10/09	Adjusted	1/31/13	1/31/13
3815099	3/9/09	3/14/09	794.38	794.38	-49.22	1	3/17/09	Adjusted	1/31/13	1/31/13
3817638	3/16/09	3/21/09	991.26	991.26	-63.28	1	3/24/09	Adjusted	1/31/13	1/31/13
3828841	3/23/09	3/24/09	168.73	168.73	-21.09	1	4/23/09	Adjusted	1/31/13	1/31/13
3828842	3/25/09	3/31/09	752.22	752.22	-77.34	1	4/23/09	Adjusted	1/31/13	1/31/13
3828843	4/1/09	4/18/09	2,587.09	2,587.09	-21.10	1	4/23/09	Adjusted	1/31/13	1/31/13
3830602	4/20/09	4/25/09	688.92	688.92	-98.44	1	4/28/09	Adjusted	1/31/13	1/31/13
3834183	4/27/09	4/29/09	246.05	246.05	-84.37	1	5/5/09	Adjusted	1/31/13	1/31/13
3834184	5/1/09	5/2/09	210.91	210.91	-21.09	1	5/5/09	Adjusted	1/31/13	1/31/13
3836756	5/4/09	5/9/09	653.78	653.78	-112.49	1	5/12/09	Adjusted	1/31/13	1/31/13
3839243	5/11/09	5/16/09	513.20	513.20	-70.31	1	5/19/09	Adjusted	1/31/13	1/31/13
3841732	5/18/09	5/23/09	1,131.82	1,131.82	-35.17	1	5/27/09	Adjusted	1/31/13	1/31/13
3843916	5/26/09	5/30/09	583.48	583.48	-21.09	1	6/2/09	Adjusted	1/31/13	1/31/13
3846759	6/1/09	6/6/09	752.22	752.22	-63.27	1	6/9/09	Adjusted	1/31/13	1/31/13
3849412	6/8/09	6/13/09	667.86	667.86	-49.23	1	6/16/09	Adjusted	1/31/13	1/31/13
3852120	6/15/09	6/20/09	710.03	710.03	-42.19	1	6/23/09	Adjusted	1/31/13	1/31/13
3854899	6/22/09	6/27/09	977.19	977.19	-56.25	1	6/30/09	Adjusted	1/31/13	1/31/13
3863003	7/13/09	7/18/09	695.97	695.97	-70.30	1	7/21/09	Adjusted	1/31/13	1/31/13
3865443	7/20/09	7/25/09	674.90	674.90	-56.26	1	7/28/09	Adjusted	1/31/13	1/31/13
3868645	7/27/09	7/31/09	562.43	562.43	-56.27	1	8/4/09	Adjusted	1/31/13	1/31/13
26 - Claims for Coverage			20,288.84	20,288.84	-1,659.39					

Coverage 1. MEDICAID (NY) NIAGARA (TPL/EDI) <21(C) 2. INDEPENDENT HEALTH (NY) CAID HMO 4. Gu

Claim #	Earliest From	Latest Thru Dt	Total Charges	Total Allowed	Balance	Curr Payor	Aging	Last Action	Last Action Dt	Review Dt
3888093	8/3/09	8/8/09	892.80	892.80	-56.27	1	9/25/09	Adjusted	1/31/13	1/31/13
3888094	8/10/09	8/15/09	822.48	822.48	-42.20	1	9/25/09	Adjusted	1/31/13	1/31/13
3888095	8/18/09	8/22/09	724.09	724.09	-21.09	1	9/25/09	Adjusted	1/31/13	1/31/13
3888098	9/7/09	9/12/09	815.49	815.49	-28.13	1	9/25/09	Adjusted	1/31/13	1/31/13
3888099	9/14/09	9/19/09	667.85	667.85	-56.26	1	9/25/09	Adjusted	1/31/13	1/31/13
3891353	9/23/09	9/26/09	590.51	590.51	-14.06	1	10/2/09	Adjusted	1/31/13	1/31/13
3891354	9/21/09	9/22/09	239.03	239.03	-14.07	1	10/2/09	Adjusted	1/31/13	1/31/13
3896075	10/5/09	10/10/09	815.50	815.50	-84.37	1	10/13/09	Adjusted	1/31/13	1/31/13
3905248	10/26/09	10/29/09	471.00	471.00	-49.24	1	11/3/09	Adjusted	1/31/13	1/31/13
3908273	11/2/09	11/7/09	864.70	864.70	-42.18	1	11/10/09	Adjusted	1/31/13	1/31/13
3914671	11/16/09	11/21/09	625.68	625.68	-49.22	1	11/24/09	Adjusted	1/31/13	1/31/13
3916925	11/23/09	11/28/09	787.36	787.36	-14.06	1	12/1/09	Adjusted	1/31/13	1/31/13
3919954	11/30/09	12/5/09	878.75	878.75	-28.13	1	12/8/09	Adjusted	1/31/13	1/31/13
3923211	12/7/09	12/12/09	892.80	892.80	-42.20	1	12/15/09	Adjusted	1/31/13	1/31/13
3926480	12/14/09	12/19/09	674.87	674.87	-70.35	1	12/22/09	Adjusted	1/31/13	1/31/13
3929530	12/21/09	12/26/09	231.97	231.97	-21.10	1	12/30/09	Adjusted	1/31/13	1/31/13
3932703	12/23/09	12/26/09	520.22	520.22	-7.03	1	1/11/10	Adjusted	1/31/13	1/31/13
3933946	1/4/10	1/9/10	906.86	906.86	-63.31	1	1/12/10	Adjusted	1/31/13	1/31/13
3936764	1/11/10	1/16/10	822.53	822.53	-56.27	1	1/19/10	Adjusted	1/31/13	1/31/13
3939906	1/18/10	1/23/10	885.77	885.77	-49.24	1	1/26/10	Adjusted	1/31/13	1/31/13
3943142	1/25/10	1/30/10	569.43	569.43	-56.25	1	2/2/10	Adjusted	1/31/13	1/31/13
3946429	2/1/10	2/6/10	892.81	892.81	-63.31	1	2/9/10	Adjusted	1/31/13	1/31/13
3949321	2/8/10	2/13/10	899.85	899.85	-7.03	1	2/16/10	Adjusted	1/31/13	1/31/13
3952606	2/14/10	2/20/10	1,110.73	1,110.73	-28.14	1	2/23/10	Adjusted	1/31/13	1/31/13
4332495	3/19/12	3/24/12	576.60	576.60	-98.58 *	1	3/27/12	Adjusted	11/9/12	11/9/12
4366966	5/21/12	5/25/12	687.11	687.11	3.01	1	5/29/12	Paid: Revi	2/5/13	2/5/13

Coverage 1. MEDICAID (NY) NIAGARA (TPL/EDI) <21(C) 2. INDEPENDENT HEALTH (NY) CAID HMO 4. Gu

Claim #	Earliest From Dt	Latest Thru Dt	Total Charges	Total Allowed	Balance	Curr Payor	Aging Dt	Last Action	Last Action Dt	Review Dt
4388073	3/5/12	3/5/12	27.55	27.55	27.55	1	7/10/12	Reminder	10/15/12	11/14/12
4388075	3/19/12	3/21/12	55.10	55.10	55.10	1	7/10/12	Reminder	10/15/12	11/14/12
4388079	3/23/12	3/23/12	27.55	27.55	27.55	1	7/10/12	Reminder	10/15/12	11/14/12
4388082	3/20/12	3/20/12	27.55	27.55	27.55	1	7/10/12	Reminder	11/12/12	12/12/12
4391601	7/11/12	7/14/12	169.42	169.42	-37.19	1	7/17/12	Adjusted	11/29/12	11/29/12
4397167	7/11/12	7/11/12	27.55	27.55	27.55	1	7/27/12	Reminder	10/29/12	11/28/12
32 - Claims for Coverage			19,201.51	19,201.51	-930.97					

Coverage 1. MEDICAID (NY) NIAGARA (TPL/EDI) >21(C) 2. INDEPENDENT HEALTH (COMMERCIAL/NON C

Claim #	Earliest From Dt	Latest Thru Dt	Total Charges	Total Allowed	Balance	Curr Payor	Aging Dt	Last Action	Last Action Dt	Review Dt
4462435	11/19/12	11/20/12	197.76	197.76	-24.72	1	11/27/12	Adjusted	1/31/13	1/31/13
4466124	11/26/12	11/30/12	414.06	414.06	-37.08	1	12/4/12	Adjusted	1/31/13	1/31/13
2 - Claims for Coverage			611.82	611.82	-61.80					

EXHIBIT "I"

From: Sheila McCray
Sent: Monday, November 11, 2013 10:57 AM
To: Kelley Altieri
Subject: CAP/C

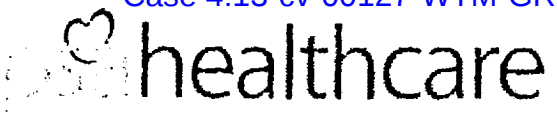
Good Morning Kelley,

I hoped you have a nice weekend. I know we briefly discussed this issue before, I just wanted to again be sure that this is what the company wants me to do. As you know, I have recently returned to work from disability leave and I'm still getting up to speed with my new duties and want to do my very best. I have been given claims from Sonya Lundie to resubmit through the portal for Greenville, NC CAP-C Program. I was told to change the NPI number from Greenville and bill through Raleigh's NPI number for claims processing, through NC Tracks.

I just want to make sure that I'm doing my job correctly in compliance with Medicaid guidelines before doing so. Do you know if we are credentialed to bill all CAP-C claims regardless of location through one NPI number, being Raleigh?

Thanks,

Sheila McCray
AR Collector, Service Center
SMccray@psahealthcare.com



3720 DaVinci Court
Suite 200
Peachtree Corners, GA 30092
770-441-1580 ext. 1183 Office | 770-248-8191 Fax

EXHIBIT "J"

From: Kelley Altieri
Sent: Tuesday, November 12, 2013 4:59 PM
To: Nateesha DeCosmo; Trellany Foster; Sheila McCray
Subject: FW: Winston Salem NC
Importance: High

FYi, taxonomy associations from Vicki Whiteside

Come see me if you need further explanation

Kelley Altieri
Accounts Receivable Manager
kaltieri@psahealthcare.com
healthcare
3720 DaVinci Court
Suite 200
Peachtree Corners, GA 30092
770-417-3268 Office | 770-248-8191 Fax

From: Vicki Whiteside
Sent: Monday, October 28, 2013 3:35 PM
To: Kelley Altieri; Kathi Miller; Frances Scovil
Cc: Marcie Gilreath; Vicki Whiteside
Subject: RE: Winston Salem NC
Importance: High

Kelley,
All of the offices have the appropriate CAP-C taxonomies registered, but we cannot bill any of the CAP-C products under the individual offices NPI until their current authorizations by the patient's case manager are updated to reflect the NPI for the office in question. Until this happens, any and all CAP services should continue to be billed under the Cary office (NPI 1114955309). This doesn't mean we will be getting paid on every claim, since there are still a lot of issues to be corrected by NCTracks and PSA.

While Marcie and I were at CSC it was brought to our attention that some of the claims submitted through the web portal had the taxonomy 251B00000X (case management) linked to them. This would be a problem since this taxonomy isn't linked to any of our offices (including Cary). There are also a lot of behind the scenes numbers that we are not privileged to and for CSC eyes only.

Marcie and I are still working with CSC and DMA trying to get clarification on the taxonomy for the billing of supplies for PDN, CAP-C and the In-Home Supports. The In-Home Supports is only billable by the Cary and Charlotte offices (taxonomy 253Z00000X). The Charlotte office is in the final stages of having this added to their NPI number.

The following is what I currently know to be correct:
251J00000X
CAP/C – Code T1000 (modifiers TD & TE)
CAP/C Respite – Code T1005 (modifiers TD & TE)

PDN – Codes T1000 (modifiers TD & TE)

253Z00000X (In-Home Support) Charlotte pending final approval by NCTracks
Cary/Charlotte – S5125 (modifier HA)
S5150 (modifier HA)
T1019
T1004

Medical Waiver Supplies
Taxonomy: 251J00000X & 332B00000X (we have received conflicting stories on which one they want us to use) Stay tuned

Marcie and I would be happy to have a conference call with you this Thursday afternoon. I can also come over to discuss. Our intent is to have a meeting with all involved as soon as we get our questions confirmed by CSC and DMA.

I hope this helps!

Regards,
Vicki Whiteside

PSA HealthCare
[redacted]

From: Kelley Altieri
Sent: Monday, October 28, 2013 11:18 AM
To: Vicki Whiteside
Cc: Marcie Gilreath
Subject: RE: Winston Salem NC

Cary, NC – 1114955309 Cap-C for Winston Salem

Kelley Altieri
Accounts Receivable Manager
kaltieri@psahealthcare.com
psahealthcare
3720 DaVinci Court
Suite 200
Peachtree Corners, GA 30092
770-417-3268 Office | 770-248-8191 Fax

From: Vicki Whiteside
Sent: Monday, October 28, 2013 10:38 AM
To: Kelley Altieri
Cc: Vicki Whiteside; Marcie Gilreath
Subject: RE: Winston Salem NC

What NPI are they using when trying to submit through the web portal?

Vicki Whiteside

HealthCare

From: Kelley Altieri
Sent: Monday, October 28, 2013 10:33 AM
To: Vicki Whiteside
Subject: Winston Salem NC

Vicki,

Do we have all the appropriate registrations for Cap in Winston Salem? We are receiving errors when trying to process via web portal?

Kelley Altieri
Accounts Receivable Manager
kaltieri@psahealthcare.com
psahealthcare
3720 DaVinci Court
Suite 200
Peachtree Corners, GA 30092
770-417-3268 Office | 770-248-8191 Fax

From: Trellany Foster
Sent: Friday, October 25, 2013 12:35 PM
To: Kelley Altieri
Subject: Need a Help Desk Ticket submitted for resolving claims reject edit 00431 for cap providers

Good Morning Kelley,

Several claims within location Winston Salem that are denying for edit code 00431 billing error. I called NC tracks there stating in order to bill for cap services on the provider profile must specifically list the appropriate taxonomy code as well as the applicable CAP service or endorsement. If the CAP service has not been added to providers profile in NC Tracks, the claim will reject with error code 00431(procedure code is not covered by the assigned bsg for the dates of service. Attached is an example of the overview on the steps we must take.

Thanks

Trellany Foster
A/R Collector, Service Center
TFoster@psahealthcare.com

healthcare

3720 DaVinci Court
Suite 200
Peachtree Corners, GA 30092
770-441-1580 Ext. 1149 Office | 770-248-8191 Fax

EXHIBIT "K"

Claim #

Rollup = Billed

From Dt	Thru Dt	Description	Qty Limits	Total Charges	Total Allowed	Balance	Total Adjustments	Adjusted Balance
)4/11/11	**0 04/11/11**	**1 LPN (HOURLY/PDN) 2ND INSU**	**10.**	**450.00**	**232.80**	**0.00**		
	5/31/11	Charge	450.00	AETNA HMO (NATL) PDN/THERA				
	6/21/11	Disallowed Reserve (System)	-217.20	AETNA HMO (NATL) PDN/THERA				
:LDP16867	6/29/11	Insurance Payment	-401.60	AETNA HMO (NATL) PDN/THERA				
	11/30/11	Disallowed Reversal	168.80	AETNA HMO (NATL) PDN/THERA				

Claim Totals:	**450.00**	**232.80**	**0.00**

EXHIBIT "L"

From Dt	Thru Dt	Description	Qty Limits	Total Charges	Total Allowed	Balance	Total Adjustments	Adjusted Balance
4/11/11	**1 04/11/11**	**1 NSG CARE IN HOME LPN PER**	**12.**	**540.00**	**481.92**	**0.00**		
	5/31/11	Charge	540.00	AETNA HMO (NATL) PDN/THERA				
	6/21/11	Disallowed Reserve (System)	-58.08	AETNA HMO (NATL) PDN/THERA				
LDP93472	11/29/11	Insurance Payment	-110.56	MEDICAID (FL) PDN TPL ONLY (				
LDP10861	4/13/12	Insurance Payment	-168.80	MEDICAID (FL) PDN TPL ONLY (				
	5/30/12	Medicaid Copay Disallowed	-202.56	MEDICAID (FL) PDN TPL ONLY (				

Claim Totals:	540.00	481.92	0.00

EXHIBIT "M"

! This claim contains data that is not valid per HIPAA 5010 specifications. This data will need to be changed to a valid value before any new action (submit or adjust) can be completed. A void request does not require a change.

Professional Claim

Billing Information

HIPAA Version	00501
ICN/TCN	
Provider ID	
Recipient ID	
Last Name	
First Name, MI	
Date of Birth	
Patient Account #*	
Referring Physician	270651200
Patient Responsibility	$0.00
Medicare Assignment*	ASSIGNED

Service Information

Release of Information*	SIGNED STMT PERMITTING RELEASE
Signature Source	GENERATED BY PROVIDER
Accident Related To	
Accident State	
Accident Country	[Search]
Accident Date	
CHCUP Referral	
PA Number	
Referral Number	

Charges

Total Charges	$990.00
Total TPL Amount	$279.36
CoPay Amount	$0.00

Diagnosis

Sequence	Qualifier	Diagnosis	Description
4	BF	V550	ATTEN TO TRACHEOSTOMY
3	BF	V551	ATTEN TO GASTROSTOMY
2	BF	V4611	RESPIRATOR DEPEND STATUS
1	BK	76521	<24 COMP WKS GESTATION

Select row above to update -or- click Add button below.

Sequence Diagnosis [Search]

TPL/Crossover

Last Name	First Name	MI	Date of Birth	Relationship	Plan Name	Policy Number
				CHILD		

Select row above to Add button below.

Relationship		Carrier	
Last Name		Plan Name	
First Name, MI		Policy Number	
Date of Birth		Member ID	
Gender		Payer Resp	
Payer Name		Claim Filing	

Detail

Item	From DOS	Procedure	M1	M2	M3	M4	Units	Charges	Status	Allowed Amount
1	04/13/2011	S9124					22.00	$990.00	PAID	$512.16

Type changes below.

Item			
Line Control Number		Drug Rebate Information	
Rendering Provider*	650648800 MCD [Search]	NDC	[Search]
From DOS*	04/13/2011		
To DOS	04/13/2011	Medicare Information	
POS*	12 [Search]	Paid Date	
Procedure*	S9124 [Search]	Paid Amount	$0.00
Modifiers	[Search] [Search]	Allowed Amount	$0.00
	[Search] [Search]	Coinsurance Amount	$0.00
Diagnosis Pointer*	1 · 2 · 3 · 4	Deductible Amount	$0.00
Units*	22.00	Copay Amount	$0.00
Charges*	$990.00		
TPL Amount	$279.36	Medicaid Information	

TPL Paid Date	06/30/2011	Status	PAID
Emergency		Allowed Amount	$512.16
CHCUP/Fam Plan		Copay Amount	$0.00

Hard-Copy Attachments

*** No rows found ***

Select row above to update -or- click Add button below.

Control Number

Transmission

Report Type

Claim Status Information

Claim Status PAID

Claim ICN

Paid Date 04/11/2012

Paid Amount $232.80

EOB Information

Detail Number	Code	Description
1	9907	TPL AMOUNT APPLIED
1	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED

Adjustment Information

ICN	Date Adjusted
5912066014872	04/03/2012
2211306006983	03/06/2012

EXHIBIT "N"

Claim # Patient #

Date	Action	Claim	Payor	Balance	Reason	User
5/30/12	**Note**		2. MEDICAID (FL) PDN TPL ON	0.00	DSA- Medicaid 2nd Disallo	COARMGLOV
	Batch # 00836-20120426-00302806-ADJ Posted by: COARMGLOV on 5/30/2012 11:26:57					
5/30/12	**Adjusted**		2. MEDICAID (FL) PDN TPL ON	0.00	DSA- Medicaid 2nd Disallo	COARMGLOV
	balance to be adjusted due to mcaid disallowed...					
4/26/12	**Adj Request**		2. MEDICAID (FL) PDN TPL ON	6.40	DSA- Medicaid 2nd Disallo	COARBBROW
	balance to be adjusted due to mcaid disallowed...					
4/13/12	**Paid: Review**		2. MEDICAID (FL) PDN TPL ON	6.40		system
4/11/12	**Bill Ins2**	CMS-1500	2. MEDICAID (FL) PDN TPL ON	597.76		system
4/11/12	**Revise Payor**		2. MEDICAID (FL) PDN TPL ON	597.76	Other	COARBBROW
	updated this clm to the correct payor...					
4/3/12	**Reminder**		1. AETNA HMO (NATL) PDN/TH	597.76	A-Cleared for Payment	COARBBROW
	updated secondary paymt on mcaid portal--per Elaine to update TPL Amt to reflect remaining 12 hours amt $279.36 (mcaid allowed amt 23.28 times 12 hours)...to be pd an additional $591.36...ICN: 5912094012556...					

EXHIBIT "O"

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i e , items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

EXHIBIT "P"

Appendix A, Home Health Services Fee Schedule, continued

CODE	MOD 1	MOD 2	MOD 3	DESCRIPTION OF SERVICE	MAXIMUM FEE
T1021	TT	GY		Home Health Aide (HHA) Visit-unassociated with skilled nursing services to a Dually-Eligible Recipient provided to more than one recipient in the same setting.	$17.46/per visit – 1st recipient $8.73/per visit for each additional recipient

PRIVATE DUTY NURSING

CODE	Mod 1	MOD 2	DESCRIPTION OF SERVICE	MAXIMUM FEE
S9123			Private duty nursing rendered by a RN (2 to 24 hours per day)*	$29.10/hr
S9123	TT		Private duty nursing rendered by a RN (2 to 24 hours per day)* provided to more than one recipient in the same setting.**	$29.10/hr – 1st recipient $14.55/hr – 2nd recipient $7.28/hr – each additional recipient
S9123	UF		Private duty nursing rendered by a RN (2 to 24 hours per day)* provided by more than one provider in the same setting***	$29.10/hr
S9123	TT	UF	Private duty nursing rendered by a RN (2 to 24 hours per day)* provided to more than one recipient by more than one provider in the same setting.*****	$29.10/hr – 1st recipient**** $14.55/hr – 2nd recipient**** $7.28/hr – each additional recipient****
S9124			Private duty nursing rendered by a LPN (2 to 24 hours per day)*	$23.28/hr
S9124	TT		Private duty nursing rendered by a LPN (2 to 24 hours per day)* provided to more than one recipient in the same setting.	$23.28/hr - 1st recipient $11.64/hr - 2nd recipient $5.82/hr - each additional recipient
S9124	UF		Private duty nursing rendered by a LPN (2 to 24 hours per day)* provided by more than one provider in the same setting	$23.28/hr
S9124	TT	UF	Private duty nursing rendered by a LPN (2 to 24 hours per day)* provided to more than one recipient in the same setting.	$23.28/hr - 1st recipient**** $11.64/hr - 2nd recipient **** $5.82/hr - each additional recipient****

*Any portion of the hour that exceeds 30 minutes may be rounded up to the next hour, but the total may not exceed the daily authorized number of hours. **The provider should bill using the TT modifier on all cases, but should reduce their billing for each as indicated in policy for subsequent cases within the same residence. ***The home health agency must add a UF modifier to the home health service procedure code to identify that services are being coordinated with another home health agency. ****Per provider.

HOME HEALTH SERVICES FEE SCHEDULE
HOME HEALTH VISITS

CODE	MOD 1	MOD 2	MOD 3	DESCRIPTION OF SERVICE	MAXIMUM FEE
T1030				Registered Nurse (RN) Visit	$31.04/per visit
T1030	TT			Registered Nurse (RN) Visit provided to more than one recipient in the same setting	$31.04/per visit - 1st recipient $15.52/per visit for each additional recipient
T1030	GY			Registered Nurse (RN) Visit to Dually-Eligible Recipient	$31.04/per visit
T1030	TT	GY		Registered Nurse (RN) Visit to Dually-Eligible Recipient provided to more than one recipient in the same setting.	$31.04/per visit – 1st recipient $15.52/per visit for each additional recipient
T1031				Licensed Practical Nurse (LPN) Visit	$26.19/per visit
T1031	TT			Licensed Practical Nurse (LPN) Visit provided to more than one recipient in the same setting.	$26.19/per visit – 1st recipient $13.10/per visit for each additional recipient
T1031	GY			Licensed Practical Nurse (LPN) Visit to Dually-Eligible Recipient	$26.19/per visit
T1031	TT	GY		Licensed Practical Nurse (LPN) Visit to Dually-Eligible Recipient provided to more than one recipient in the same setting.	$26.19/per visit – 1st recipient $13.10/per visit for each additional recipient
T1021				Home Health Aide (HHA) Visit-unassociated with skilled nursing services	$17.46/per visit
T1021	TD			Home Health Aide (HHA) Visit-associated with skilled nursing services	$17.46/per visit
T1021	TT			Home Health Aide (HHA) Visit-unassociated with skilled nursing services provided to more than one recipient in the same setting.	$17.46/per visit – 1st recipient $8.73/per visit for each additional recipient
T1021	GY			Home Health Aide (HHA) Visit-unassociated with skilled nursing services to a Dually-Eligible Recipient	$17.46/per visit
T1021	TD	TT		Home Health Aide (HHA) Visit-associated with skilled nursing services provided to more than one recipient in the same setting.	$17.46/per visit – 1st recipient $8.73/per visit for each additional recipient
T1021	TD	GY		Home Health Aide (HHA) Visit-associated with skilled nursing services to Dually-Eligible Recipient	$17.46/per visit
T1021	TD	TT	GY	Home Health Aide (HHA) Visit-associated with skilled nursing services to Dually-Eligible Recipient provided to more than one recipient in the same setting.	$17.46/per visit – 1st recipient $8.73/per visit for each additional recipient

EXHIBIT "Q"

Claim # Rollup = None

From Dt	Thru Dt	Description	Qty Limits	Total Charges	Total Allowed	Balance	Total Adjustments	Adjusted Balance
8/05/12	**1 08/05/12**	**(NSG CARE IN HOME LPN PER**	**7. Bill**	**315.00**	**162.96**	**0.00**		
	8/14/12	Charge	315.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-152.04	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-162.96	MEDICAID (FL) PDN (C)				
8/05/12	**1 08/06/12**	**1 NSG CARE IN HOME LPN PER**	**1. Bill**	**45.00**	**23.28**	**0.00**		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
8/06/12	**1 08/06/12**	**(NSG CARE IN HOME LPN PER**	**7. Bill**	**315.00**	**162.96**	**0.00**		
	8/14/12	Charge	315.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-152.04	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-162.96	MEDICAID (FL) PDN (C)				
8/06/12	**(08/06/12**	**(NSG CARE IN HOME LPN PER**	**.25 Bill**	**11.25**	**5.82**	**0.00**		
	8/14/12	Charge	11.25	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-5.43	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-5.82	MEDICAID (FL) PDN (C)				
8/06/12	**(08/06/12**	**(NSG CARE IN HOME LPN PER**	**.75 Bill**	**33.75**	**17.46**	**0.00**		
	8/14/12	Charge	33.75	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-16.29	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-17.46	MEDICAID (FL) PDN (C)				
8/06/12	**(08/06/12**	**(NSG CARE IN HOME LPN PER**	**7. Bill**	**315.00**	**162.96**	**0.00**		
	8/14/12	Charge	315.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-152.04	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-162.96	MEDICAID (FL) PDN (C)				
8/06/12	**(08/06/12**	**(NSG CARE IN HOME LPN PER**	**1. Bill**	**45.00**	**23.28**	**0.00**		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
8/06/12	**(08/06/12**	**(NSG CARE IN HOME LPN PER**	**1. Bill**	**45.00**	**23.28**	**0.00**		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
8/06/12	**1 08/06/12**	**1 NSG CARE IN HOME LPN PER**	**1. Bill**	**45.00**	**23.28**	**0.00**		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
8/06/12	**1 08/07/12**	**1 NSG CARE IN HOME LPN PER**	**1. Bill**	**45.00**	**23.28**	**0.00**		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
8/07/12	**1 08/07/12**	**(NSG CARE IN HOME LPN PER**	**7. Bill**	**315.00**	**162.96**	**0.00**		
	8/14/12	Charge	315.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-152.04	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-162.96	MEDICAID (FL) PDN (C)				
8/07/12	**(08/07/12**	**(NSG CARE IN HOME LPN PER**	**.5 Bill**	**22.50**	**11.64**	**0.00**		
	8/14/12	Charge	22.50	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-10.86	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Qty Rounding Adjustment	11.64	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
8/07/12	**(08/07/12**	**(NSG CARE IN HOME LPN PER**	**.5 Bill**	**22.50**	**11.64**	**0.00**		
	8/14/12	Charge	22.50	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-10.86	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-11.64	MEDICAID (FL) PDN (C)				
8/07/12	**(08/07/12**	**(NSG CARE IN HOME LPN PER**	**7. Bill**	**315.00**	**162.96**	**0.00**		
	8/14/12	Charge	315.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-152.04	MEDICAID (FL) PDN (C)				

Claim Totals:	5,017.50	2,595.72	0.00

Claim # Rollup = None

From Dt	Thru Dt	Description	Qty Limits	Total Charges	Tota Allowed	Balance	Total Adjustments	Adjusted Balance
08/07/12	(08/07/12	(NSG CARE IN HOME LPN PER	7. Bill	315.00	162.96	0.00		
ELDP10474	8/23/12	Insurance Payment	-162.96	MEDICAID (FL) PDN (C)				
08/07/12	(08/07/12	(NSG CARE IN HOME LPN PER	1. Bill	45.00	23.28	0.00		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
ELDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
08/07/12	(08/07/12	(NSG CARE IN HOME LPN PER	.5 Bill	22.50	11.64	0.00		
	8/14/12	Charge	22.50	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-10.86	MEDICAID (FL) PDN (C)				
ELDP10474	8/23/12	Insurance Payment	-11.64	MEDICAID (FL) PDN (C)				
08/07/12	1 08/07/12	1 NSG CARE IN HOME LPN PER	1. Bill	45.00	23.28	0.00		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
ELDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
08/07/12	1 08/08/12	1 NSG CARE IN HOME LPN PER	1. Bill	45.00	23.28	0.00		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
ELDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
08/08/12	1 08/08/12	(NSG CARE IN HOME LPN PER	7. Bill	315.00	162.96	0.00		
	8/14/12	Charge	315.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-152.04	MEDICAID (FL) PDN (C)				
ELDP10474	8/23/12	Insurance Payment	-162.96	MEDICAID (FL) PDN (C)				
08/08/12	(08/08/12	(NSG CARE IN HOME LPN PER	1. Bill	45.00	23.28	0.00		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
ELDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
08/08/12	(08/08/12	(NSG CARE IN HOME LPN PER	7. Bill	315.00	162.96	0.00		
	8/14/12	Charge	315.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-152.04	MEDICAID (FL) PDN (C)				
ELDP10474	8/23/12	Insurance Payment	-162.96	MEDICAID (FL) PDN (C)				
08/08/12	(08/08/12	(NSG CARE IN HOME LPN PER	1. Bill	45.00	23.28	0.00		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
ELDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
08/08/12	(08/08/12	(NSG CARE IN HOME LPN PER	.75 Bill	33.75	17.46	0.00		
	8/14/12	Charge	33.75	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-16.29	MEDICAID (FL) PDN (C)				
ELDP10474	8/23/12	Qty Rounding Adjustment	5.82	MEDICAID (FL) PDN (C)				
ELDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
08/08/12	1 08/08/12	1 NSG CARE IN HOME LPN PER	1. Bill	45.00	23.28	0.00		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
08/08/12	1 08/09/12	1 NSG CARE IN HOME LPN PER	1. Bill	45.00	23.28	0.00		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
08/09/12	1 08/09/12	(NSG CARE IN HOME LPN PER	7. Bill	315.00	162.96	0.00		
	8/14/12	Charge	315.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-152.04	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-162.96	MEDICAID (FL) PDN (C)				
08/09/12	(08/09/12	(NSG CARE IN HOME LPN PER	1. Bill	45.00	23.28	0.00		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				

Claim Totals:	5,017.50	2,595.72	0.00

Claim #

Rollup = None

From Dt	Thru Dt	Description	Qty Limits	Total Charges	Total Allowed	Balance	Total Adjustments	Adjusted Balance
08/09/12	(08/09/12	(NSG CARE IN HOME LPN PER	7. Bill	315.00	162.96	0.00		
	8/14/12	Charge	315.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-152.04	MEDICAID (FL) PDN (C)				
ELDP10474	8/23/12	Insurance Payment	-162.96	MEDICAID (FL) PDN (C)				
08/09/12	(08/09/12	(NSG CARE IN HOME LPN PER	1. Bill	45.00	23.28	0.00		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
ELDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
08/09/12	(08/09/12	(NSG CARE IN HOME LPN PER	.75 Bill	33.75	17.46	0.00		
	8/14/12	Charge	33.75	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-16.29	MEDICAID (FL) PDN (C)				
ELDP10474	8/23/12	Qty Rounding Adjustment	5.82	MEDICAID (FL) PDN (C)				
ELDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
08/09/12	1 08/09/12	1 NSG CARE IN HOME LPN PER	1. Bill	45.00	23.28	0.00		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
ELDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
08/09/12	1 08/10/12	1 NSG CARE IN HOME LPN PER	1. Bill	45.00	23.28	0.00		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
08/10/12	1 08/10/12	(NSG CARE IN HOME LPN PER	7. Bill	315.00	162.96	0.00		
	8/14/12	Charge	315.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-152.04	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-162.96	MEDICAID (FL) PDN (C)				
8/10/12	(08/10/12	(NSG CARE IN HOME LPN PER	1. Bill	45.00	23.28	0.00		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
8/10/12	(08/10/12	(NSG CARE IN HOME LPN PER	7. Bill	315.00	162.96	0.00		
	8/14/12	Charge	315.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-152.04	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-162.96	MEDICAID (FL) PDN (C)				
8/10/12	(08/10/12	(NSG CARE IN HOME LPN PER	.5 Bill	22.50	11.64	0.00		
	8/14/12	Charge	22.50	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-10.86	MEDICAID (FL) PDN (C)				
_DP10474	8/23/12	Qty Rounding Adjustment	11.64	MEDICAID (FL) PDN (C)				
_DP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
8/11/12	(08/11/12	(NSG CARE IN HOME LPN PER	1. Bill	45.00	23.28	0.00		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
_DP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
8/11/12	(08/11/12	(NSG CARE IN HOME LPN PER	7. Bill	315.00	162.96	0.00		
	8/14/12	Charge	315.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-152.04	MEDICAID (FL) PDN (C)				
_DP10474	8/23/12	Insurance Payment	-162.96	MEDICAID (FL) PDN (C)				
8/11/12	(08/11/12	(NSG CARE IN HOME LPN PER	1. Bill	45.00	23.28	0.00		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
_DP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
8/11/12	(08/11/12	(NSG CARE IN HOME LPN PER	1. Bill	45.00	23.28	0.00		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
_DP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				
8/11/12	(08/11/12	1 NSG CARE IN HOME LPN PER	2. Bill	90.00	46.56	0.00		
	8/14/12	Charge	90.00	MEDICAID (FL) PDN (C)				

Claim Totals: 5,017.50 2,595.72 0.00

Claim #

Rollup = None

From Dt	Thru Dt	Description	Qty Limits	Total Charges	Total Allowed	Balance	Total Adjustments	Adjusted Balance
08/11/12	08/11/12	1 NSG CARE IN HOME LPN PER	2. Bill	90.00	46.56	0.00		
	8/14/12	Disallowed Reserve (System)	-43.44	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-46.56	MEDICAID (FL) PDN (C)				
08/11/12	08/12/12	1 NSG CARE IN HOME LPN PER	1. Bill	45.00	23.28	0.00		
	8/14/12	Charge	45.00	MEDICAID (FL) PDN (C)				
	8/14/12	Disallowed Reserve (System)	-21.72	MEDICAID (FL) PDN (C)				
LDP10474	8/23/12	Insurance Payment	-23.28	MEDICAID (FL) PDN (C)				

Claim Totals:	5,017.50	2,595.72	0.00

EXHIBIT "R"

Pre-Pay Report

NURSING

Location / Payor / Patient Name - Patient #	Entry Date	Batch Number	Check Number	Payment Amount Unapplied
120 - CLERMONT, FL - NURSING				
SA Patients				
5120 - D*INSURANCE DESIGN ADMIN(C) PPONEXT/PHN/				
	12/17/2012	358548	3958	($50.00)
	12/17/2012	358548	3950	($50.00)
5742 - MEDICAID (FL) PDN (C)				
	10/25/2013	378470	ELDP3088344	($1,094.16)
0 - PRIVATE PAY (WEEKLY BILLING)				
	06/27/2011	331628	VS87630	($40.00)
5742 - MEDICAID (FL) PDN (C)				
	10/11/2013	377591	ELDP5832408	($162.96)
	07/12/2013	372210	ELDP3043608	($186.24)
	12/21/2012	358826	ELDP2023032	($186.24)

Pre-Pay Report

NURSING

Location / Payor / Patient Name - Patient #	Entry Date	Batch Number	Check Number	Payment Amount Unapplied
7 - GREENVILLE, NC - NURSING				
'SA Patients				
5886 - MEDICAID (NC) CAP-C(TPL NSG & SUPPLIES(C				
	04/22/2011	329092	ELDP6231814	($440.64)
10014 - BC/BS (NC) BLUECARD VISITS (NO CONTRACT				
	06/22/2012	348910	120124	($280.00)
0 - PRIVATE PAY (WEEKLY BILLING)				
	01/11/2012	340021	2987	($20.00)

Pre-Pay Report

NURSING

Location / Payor / Patient Name - Patient #	Entry Date	Batch Number	Check Number	Payment Amount Unapplied
401 - LONGVIEW, WA - NURSING				
SA Patients				
Guarantor				
	03/13/2013	363693	3770	($203.00)
4654 - MEDICAID (WA) SWAAD/PERSONAL CARE SVC(C)				
	07/22/2011	332487	386832	($147.34)

NURSING

Location / Payor / Patient Name - Patient #	Entry Date	Batch Number	Check Number	Payment Amount Unapplied
) - AUGUSTA, GA - NURSING				
SA Patients				
Guarantor				
	10/16/2013	377804	2893	($50.00)
	10/16/2013	377804	3420	($50.00)
9848 - MEDICAID (SC) (CNS) (ENHANCED) (C)				
	12/03/2009	309569	ELDP1107800	($514.80)
	12/22/2009	310351	ELDP888640	($324.00)
9849 - MEDICAID (SC) CNS TPL (ENHANCED)(C)				
	07/19/2010	319454	ELDP1060160	($1,156.40)
9848 - MEDICAID (SC) (CNS) (ENHANCED) (C)				
	02/26/2010	313233	ELDP846400	($238.00)
	12/03/2009	309569	ELDP1107800	($534.80)
	12/30/2009	310786	ELDP492320	($232.40)
	01/22/2010	311655	ELDP802440	($820.80)
0 - PRIVATE PAY (WEEKLY BILLING)				
	12/14/2012	358495	462	($150.00)
	12/14/2012	358495	464	($150.00)
9849 - MEDICAID (SC) CNS TPL (ENHANCED)(C)				
	06/06/2012	348154	ELDP832640	($198.80)
	06/06/2012	348155	ELDP832640	($231.00)
	06/06/2012	348157	ELDP832640	($244.44)
	06/06/2012	348158	ELDP832640	($112.56)
	12/06/2010	324401	ELDP960440	($442.80)
9920 - MEDICAID (SC) MCCW AREA 12 (ENHANCED)(C)				
	03/15/2013	363860	ELDP2349882	$181.26
	10/10/2013	377522	ELDP2349882	($44.46)
	10/10/2013	377523	ELDP2349882	($136.80)

Pre-Pay Report

NURSING

Location

Payor

Patient Name - Patient #	Entry Date	Batch Number	Check Number	Payment Amount Unapplied
100 - Z-CLEARWATER, FL - NURSING				
SA Patients				
5742 - MEDICAID (FL) PDN (C)				
	02/28/2013	362931	ELDP2861694	($6,076.08)
	03/25/2013	364399	ELDP1776264	($2,095.20)

Pre-Pay Report

NURSING

Location / Payor / Patient Name - Patient #	Entry Date	Batch Number	Check Number	Payment Amount Unapplied
'460 - TACOMA, WA - NURSING				
'SA Patients				
9878 - D*ALIGNSTAFFING/RESPITE CARE NET(NATL				
	06/12/2012	348440	23636	($320 00)
	03/06/2012	343148	23458	($213.75)
0 - PRIVATE PAY (WEEKLY BILLING)				
	11/08/2012	356579	5034	($30.00)
9878 - D*ALIGNSTAFFING/RESPITE CARE NET(NATL				
	04/13/2012	345135	23530	($360.00)
10265 - TRUSTEED PLANS (WA)				
	12/04/2012	357875	113974469	($874.65)
9878 - D*ALIGNSTAFFING/RESPITE CARE NET(NATL				
	11/07/2012	356299	23909	($11.25)
	10/11/2011	335456	21065	($112.50)
	04/13/2012	345135	23530	($135.00)
	04/16/2013	365968	24342	($61.50)
	11/07/2012	356299	23909	($360.00)
	11/07/2012	356299	23909	($80.00)
	12/11/2012	358182	23953	($11.25)
	12/11/2012	358223	24025	($11.25)

NURSING

Location / Payor / Patient Name - Patient #	Entry Date	Batch Number	Check Number	Payment Amount Unapplied
501 - SACRAMENTO, CA - NURSING				
SA Patients				
9352 - O/P MEDI CAL 2 (IHMC TPL ONLY) OVER 21				
	10/02/2013	376929	ELDP4412136	($232.93)
0 - PRIVATE PAY (WEEKLY BILLING)				
	08/30/2010	321271	VS3938	($63.00)
atients with no account				
10467 - PARTNERSHIP HEALTHCARE PLAN (CA) (TPL)				
	10/25/2013	378693	807350	($1,455.50)
8113 - BLUE SHIELD (CA) (HMO/PPO)(C)				
	02/28/2011	327066	ELDP12744	($127.44)
9346 - PARTNERSHIP HEALTHCARE PLAN(CA)(MEDICAL)				
	10/25/2013	378685	809060	($1,399.89)
	10/25/2013	378685	808510	($89.94)

EXHIBIT "S"

Sheila McCray

From: Elizabeth Adams
Sent: Thursday, March 28, 2013 11:22 AM
To: Sheila McCray
Subject: RE:

I attempted to get a Medicaid EPSDT auth but they will not give me one because this patient is 22 years old and EPSDT is for young children. This patient has Medicaid but the only auth we are able to get for skilled nursing is EDCD respite. My understanding is that her insurance copay is not able to be billed to respite. I believe our policy is that if the patient has Medicaid we do not bill the parent for their coinsurance. In the past we have written off the co insurance for this patient.

Does someone else in AR want to weigh in on this?

Beth

Healthcare

Beth Adams, RN
Location Director
Northern Virginia
5278 Lyngate Ct.
Burke, VA 22015
Phone: 703-873-7672
Toll free: 800-238-0827
Fax: 703-455-3291
Email: eadams@psahealthcare.com
Website: www.psahealthcare.com

From: Sheila McCray
Sent: Thursday, March 21, 2013 2:53 PM
To: Elizabeth Adams
Subject: RE:

Ok, thanks...Once you update me, I'll let the parent know as well.

On another note: should be paid very shortly

From: Elizabeth Adams
Sent: Thursday, March 21, 2013 2:50 PM
To: Sheila McCray
Subject: RE:

Yes I will have to get a Medicaid EPSDT auth with a dx code but probably going to be impossible. I will try, but because of changes in Medicaid procedures as of 1/1/13 for the waiver she is on I am not hopeful. If I can't get it we will have to write it off.

healthcare

Beth Adams, RN
Location Director
Northern Virginia
5278 Lyngate Ct
Burke VA 22015
Phone: 703-873-7672
Toll free: 800-236-0827
Fax: 703-455-3291
Email: eadams@psahealthcare.com
Website: www.psahealthcare.com

From: Sheila McCray
Sent: Thursday, March 21, 2013 2:48 PM
To: Elizabeth Adams
Cc: Sheila McCray
Subject:

Hello Beth.

This patient has a coinsurance amount and wants to know if we can bill Medicaid instead of billing her for the balance...

Sheila McCray, CPC, RHIT | A/R Collector, Shared Services | PSA Healthcare
3720 DaVinci Court, Suite 200 Norcross, GA 30092 | smccray@psahealthcare.com
o: 770-441-1580 Ext. 1183 | f: 770-242-8190
www.psahealthcare.com

Sheila McCray

From: Elizabeth Adams
Sent: Thursday, March 21, 2013 2:50 PM
To: Sheila McCray
Subject: RE:

Yes. I will have to get a Medicaid EPSDT auth which is probably going to be impossible. I will try, but because of changes in Medicaid procedures as of 11/1/12 for the waiver she is on, I am not hopeful. If I can't get it we will have to write it off.

Beth Adams, RN
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Email: eadams@psahealthcare.com
Website: www.psahealthcare.com

From: Sheila McCray
Sent: Thursday, March 21, 2013 2:48 PM
To: Elizabeth Adams
Cc: Sheila McCray
Subject:

Hello Beth.

This patient has a coinsurance amount and wants to know if we can bill Medicaid instead of billing her for the balance...

Sheila McCray, CPC, RHIT | A/R Collector, Shared Services | PSA Healthcare
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o: 770-441-1580 Ext. 1193 | f: 770-248-8190
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