

FILED
WILLIAMSON COUNTY
CIRCUIT COURT

IN THE CIRCUIT COURT FOR WILLIAMSON COUNTY, TENNESSEE
AT FRANKLIN

2017 MAY 10 PM 1:19

STATE OF TENNESSEE,

Plaintiff,

v.

PAIN MD, LLC, MEDMANAGEMENT, INC., MID-
SOUTH PAIN MANAGEMENT, P.C., MEDCORE, P.C.,
CUMBERLAND BACK PAIN CLINIC, P.C., LEBANON
BACK PAIN CLINIC, P.C., MICHAEL KESTNER, and
LISABETH WILLIAMS née SMOLENSKI,

Defendants.

Civil Action No.

2017-262

Jury Demand

COMPLAINT

This action, brought by the State of Tennessee against the defendants named above, seeks civil penalties and treble damages under the Tennessee Medicaid False Claims Act, Tenn. Code Ann. §§ 71-5-181 to -185 (TMFCA).

Defendants comprise, own, operate, or are employed by an organization of pain management clinics throughout Tennessee. The clinics purport to treat patients who suffer from chronic pain. Instead of providing quality treatment to these patients, Defendants prioritize what Defendant Michael Kestner euphemistically calls "medical economics" over appropriate care and honest billing, resulting in the submission of millions of dollars of fraudulent claims to government healthcare programs.

Since at least 2006, Defendants have conducted a scheme whereby insured patients who wanted a prescription for pain medication were pressured into also submitting to, typically, 6-20

trigger-point injections in their backs, but up to as many as 50 shots in one office visit. Defendants could legally bill government healthcare plans for only one trigger-point injection per office visit, regardless of the actual number of injections performed, so they fraudulently billed for tendon injections—a very different procedure—for which there is no billing limit per office visit because honest, qualified providers would rarely, if ever, administer more than one tendon injection during a single office visit.

Additionally, when Defendants' healthcare providers perform a procedure on an established patient, they are permitted to bill only for the reimbursement code associated with that procedure, and not for the office visit generally, unless the provider also performs a significant, separately identifiable service. When billing government healthcare programs, Defendants routinely improperly used what is called "Modifier 25" to fraudulently avoid this limitation and bill separately for services that were included in the reimbursement for the procedure.

By falsely billing trigger-point injections as tendon injections and performing a medically unnecessary high volume of them on their patients, and by abusing Modifier 25, Defendants knowingly caused government healthcare programs to be wrongfully billed for thousands of tendon injection procedures and for accompanying office visits. Upon information and belief, the State of Tennessee alleges the following:

JURISDICTION AND VENUE

1. This Court has jurisdiction over this action under Tenn. Code Ann. § 71-5-183.
2. Venue lies in this judicial district pursuant to Tenn. Code Ann. § 71-5-185, because a substantial part of the events and omissions giving rise to the claims alleged occurred in this judicial district and because the Corporate Defendants operate and are located here.

3. This Court may exercise personal jurisdiction over Defendants Mr. Kestner and Dr. Williams pursuant to Tenn. Code Ann. §§ 20-2-222 and 223, and because they transacted business in this judicial district during the relevant period, and because Defendant Dr. Williams lives here.

THE PARTIES

PLAINTIFF

4. Plaintiff State of Tennessee brings this action through the Tennessee Attorney General, on behalf of its state Medicaid program, known as TennCare. The Attorney General has standing to bring this action pursuant to Tenn. Code Ann. § 71-5-183(a).

DEFENDANTS

Corporate Defendants

5. All Corporate Defendants—Pain MD, LLC (Pain MD), MedManagement, Inc., Mid-South Pain Management, P.C. (Mid-South Pain Management), Cumberland Back Pain Clinic, P.C., Lebanon Back Pain Clinic, P.C., and MedCore, P.C. (MedCore) (collectively, Corporate Defendants)—comprise a single business enterprise, known as MMi, which is controlled primarily by Defendant Mr. Kestner in partnership to some extent with Defendant Dr. Williams.

6. Defendant Pain MD, LLC, d/b/a MMi, is a Delaware limited liability company with a principal place of business at 725 Cool Springs Boulevard, Suite 550, Franklin, Tennessee 37069. Pain MD is owned and operated by Mr. Kestner.

7. Defendant MedManagement, Inc., d/b/a MMi, is a Tennessee corporation with a principal place of business at 725 Cool Springs Boulevard, Suite 550, Franklin, Tennessee 37069. MedManagement, Inc. is owned and operated by Mr. Kestner.

8. Defendant Mid-South Pain Management, P.C., d/b/a MMi, is a Tennessee professional corporation with a principal place of business at 725 Cool Springs Boulevard, Suite 550, Franklin, Tennessee 37069. Mid-South Pain Management is owned by Dr. Williams, but operation and control of Mid-South Pain Management is shared between Dr. Williams and Mr. Kestner. Mid-South Pain Management is sued in its own capacity and as successor in interest to Blue Mountain Medical Associates, P.C., Fall Creek Medical Management, P.C., Natural Bridge Medical Group, P.C., New River Medical Associates, P.C., Rock Island Medical Group, P.C., and Stones River Medical Management, P.C., all of which were owned or operated by Dr. Williams.

9. Defendant Cumberland Back Pain Clinic, P.C., d/b/a MMi, is a Tennessee professional corporation with a principal place of business at 725 Cool Springs Boulevard, Suite 550, Franklin, Tennessee 37069. It is owned by Dr. Williams, but operation and control of Cumberland Back Pain Clinic is shared by Dr. Williams and Mr. Kestner. In October 2013, Dr. Williams merged all assets of Cumberland Back Pain Clinic into Mid-South Pain Management.

10. Defendant Lebanon Back Pain Clinic, P.C., d/b/a MMi, is a Tennessee professional corporation with a principal place of business at 725 Cool Springs Boulevard, Suite 550, Franklin, Tennessee 37069. It is owned by Dr. Williams, but operation and control of Lebanon Back Pain Clinic is shared by Dr. Williams and Mr. Kestner. In October 2013, Dr. Williams merged all assets of Lebanon Back Pain Clinic into Mid-South Pain Management.

11. In December 2013, Mr. Kestner and Dr. Williams merged all assets of MedManagement, Inc. and Mid-South Pain Management into Pain MD, which is owned and operated by Mr. Kestner.

12. Defendant MedCore, P.C., d/b/a MMi, is a Tennessee professional corporation with a principal place of business at 725 Cool Springs Boulevard, Suite 550, Franklin, Tennessee 37069. MedCore is owned by Dr. Williams, but operation and control of MedCore is shared between Dr. Williams and Mr. Kestner. It provides medical director services to Pain MD.

13. All Corporate Defendants are doing business as MMi. Any reference to MMi in this Complaint is intended to include the entire business enterprise consisting of all Corporate Defendants.

Individual Defendants

14. Defendant Michael Kestner is a Tennessee resident and a lawyer by education. Mr. Kestner exercises ultimate control and authority over all of the MMi entities by virtue of a mixture of direct ownership, influence exerted through contractual arrangements, and the force of his personality.

15. Defendant Dr. Lisabeth Williams née Smolenski resides in and is licensed to practice medicine in Tennessee. Dr. Williams owned the pain management clinics and was and/or is an MMi Supervising Physician. Dr. Williams is also the Medical Director of Pain MD.

LEGAL AND REGULATORY BACKGROUND

THE MEDICAID/TENNCARE PROGRAM

16. The Medicaid Program, enacted under title XIX of the Social Security Act of 1965, 42 U.S.C. § 1396 et seq., provides funding for medical and health-related services for certain individuals and families with low incomes and virtually no financial resources. Those eligible for Medicaid include pregnant women, children, and persons who are blind or suffer from other disabilities and who cannot afford the cost of healthcare. 42 U.S.C. § 1396d. The Medicaid program is a joint federal–state program. 42 U.S.C. § 1396b. If a state elects to participate in the program, the costs of Medicaid are shared between the state and the federal government. 42 U.S.C. § 1396a(a)(2). In order to receive federal funding, a participating state must comply with requirements imposed by the Social Security Act and regulations promulgated thereunder.

17. The State of Tennessee participates in the Medicaid program pursuant to Tenn. Code Ann. §§ 71-5-101 to -199. The federal government, through the Centers for Medicare & Medicaid Services (CMS), provides approximately 65% of the funds used by the Tennessee Medicaid program to provide medical assistance to persons enrolled in the Medicaid program.

18. In return for receipt of federal subsidies, the State of Tennessee is required to administer its Medicaid program in conformity with a state plan that satisfies the requirements of the Social Security Act and accompanying regulations. 42 U.S.C. §§ 1396–1396vj; Tenn. Code Ann. § 71-5-102. In Tennessee, the Department of Finance & Administration (F&A) administers the state Medicaid program through the Bureau of TennCare (TennCare). Tenn. Code Ann. § 71-5-104. TennCare operates as a special demonstration project authorized by the Secretary of the Department of Health and Human Services under the waiver authority conferred by 42

U.S.C. § 1315. F&A supervises TennCare's administration of medical assistance for eligible recipients. Tenn. Code Ann. §§ 71-5-105 to -107. F&A is authorized to promulgate rules and regulations to carry out the purposes of TennCare. Tenn. Code Ann. §§ 71-5-124 to -134.

19. TennCare contracts with private managed care contractors (MCCs) through contracts known as Contractor Risk Agreements (CRAs), which must conform to the requirements of 42 U.S.C. § 1395mm, along with any related federal rules and regulations. Tenn. Code Ann. § 71-5-128. The MCCs contract directly with healthcare providers to provide services to eligible TennCare beneficiaries. Providers who have entered into such a contract with an MCC are known as Participating Providers. Tenn. Comp. R. & Regs. § 1200-13-13-.01(91). Pursuant to the CRAs, TennCare distributes the combined state and federal Medicaid funding to the MCCs, which then pay Participating Providers for treatment of TennCare beneficiaries. TennCare-eligible persons seeking medical assistance enroll with an MCC to receive healthcare services from a Participating Provider.

20. To obtain TennCare reimbursement for certain outpatient items or services, providers and suppliers submit claims using certain five-digit codes, known as Current Procedural Terminology (CPT) codes, that identify the services rendered and for which reimbursement is sought, and the unique billing identification number of the "rendering provider." *See* 45 C.F.R. § 162.1002. The MCCs assign reimbursement amounts to CPT codes.

21. Providers who seek reimbursement for office visits with established patients are required to use one of the range of CPT codes for Evaluation and Management (E&M) services from 99211 through 99215 on their claims.

22. Providers who seek reimbursement for providing tendon injections to patients are required to use CPT code 20550 or 20551.

23. Providers who seek reimbursement for providing trigger-point injections to patients are required to use CPT code 20552 or 20553.

24. When a medically necessary, significant, and separately identifiable E&M service is performed in addition to a service such as an injection, the appropriate E&M code should be submitted with a designation known as "Modifier 25."

TENNCARE REIMBURSEMENT REQUIREMENTS

25. TennCare supervises the administration of medical assistance for eligible recipients. Tenn. Code Ann. § 71-5-105(a)(1). The term "medical assistance," defined at 42 U.S.C. § 1396d and Tenn. Code Ann. § 71-5-103(7), includes payment for the cost of provision of medical services by qualified, licensed practitioners to an eligible person.

26. TennCare will only pay for services that are within the scope of the TennCare program and that are medically necessary. Tenn. Code Ann. § 71-5-144(a). Thus, TennCare regulations and the CRAs include requirements that Participating Providers can bill only for medically necessary services. Adherence to medical necessity requirements is a central tenet of the TennCare program and goes to the very essence of the bargain between TennCare and Participating Providers.

27. A service is not medically necessary under the TennCare program unless it is "safe and effective." To qualify as safe and effective, the type and level of service must be consistent with the symptoms or diagnosis and treatment of the particular medical condition, and the reasonably anticipated medical benefits of the service must outweigh the anticipated medical risks based on the patient's condition and scientifically supported evidence. Tenn. Code Ann. § 71-5-144(b)(2).

28. A service is not medically necessary under the TennCare program if it is “experimental or investigational.” A service is experimental or investigational if there is inadequate empirically based objective clinical scientific evidence of its safety and effectiveness for the particular use in question. A provider’s subjective clinical judgment on the safety and effectiveness of a service does not satisfy this standard, nor does a reasonable medical or clinical hypothesis based on extrapolation from use in another setting or from use in diagnosing or treating another condition. Tenn. Code Ann. § 71-5-144(b)(4)(A).

29. A service is not medically necessary under the TennCare program unless it is the “least costly alternative course of diagnosis or treatment that is adequate for the medical condition of the enrollee.” Tenn. Code Ann. § 71-5-144(b)(3).

30. A service is not medically necessary under the TennCare program unless it is “required in order to diagnose or treat an enrollee’s medical condition.” Tenn. Code Ann. § 71-5-144(b)(1).

31. In order to be reimbursed for services provided to TennCare enrollees, a Participating Provider must submit claims to TennCare using a standardized process that includes standard claims forms and standardized coding to identify diagnoses and services provided. Tenn. Code Ann. § 71-5-191.

32. To be eligible to bill and receive reimbursement for services provided to TennCare enrollees, a Participating Provider must possess a unique provider identification number. All claims for reimbursement must be submitted under a valid provider identification number for the identified provider. 42 C.F.R. § 455.440.

33. Participating Providers submit claims for reimbursement for services to MCCs through either paper or electronic forms. On these forms, the provider identifies the services for

which reimbursement is sought using standard, uniform code numbers such as CPT codes. TennCare and the MCCs have adopted the CPT Manual—a reference guide published by the American Medical Association that lists the identifying codes and describes the corresponding services—for the purpose of identifying services for which providers seek reimbursement. Each CPT code corresponds to a specific service as described in the CPT Manual.

34. A Participating Provider must properly document in the patient's medical record the service performed. 42 C.F.R. § 431.107(b)(1).

35. For some CPT codes, a provider may bill multiple units of that code as part of a single claim for reimbursement, as long as those multiple units accurately reflect medically necessary services that were actually performed. For example, if a CPT code represents a procedure for a knee replacement, and the patient needs both knees replaced at the same time, the provider may submit a single claim for two units of that code. Some examples of units for different CPT codes are days, hours, number of injections, or number of doses prepared.

36. For other CPT codes, however, billing is limited. This limitation is usually for procedures that—unlike knee replacements—can be performed many times. An MCC or TennCare may place a cap on the number of units of a particular code that may be billed within a certain time period. For example, an MCC may limit the number of doses of allergen immunotherapy that may be billed for treatment of a patient over the course of a year. Or in some instances, the CPT code definition itself may limit billing for the services performed to a single unit. For example, the CPT codes for trigger-point injections must be billed only as a single unit per patient visit regardless of how many injections are performed.

37. Typically, a Participating Provider does not include medical records when submitting a claim to an MCC. TennCare, through the MCCs, processes approximately five million

claims for payment per month, totaling \$7.7 billion in payments per year to 45,000 Participating Providers. Because most Participating Providers are honest, and because of the enormous volume of claims being processed every day, TennCare's reimbursement of providers has historically focused on prompt payment. In fact, MCCs are required by contract and statute to pay claims quickly. Tenn. Code Ann. § 56-32-126. In return, providers are required by law to file true and correct claims. Tenn. Code Ann. § 71-5-182. While prompt pay requirements benefit honest providers, they make it difficult for TennCare and the MCCs to identify fraudulent billing before making payment. Thus, fraud detection and recovery efforts generally arise after payment.

TENNESSEE MEDICAID FALSE CLAIMS ACT

38. The TMFCA creates a cause of action for the State of Tennessee against any person who:

- (A) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval under the medicaid program;
- (B) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim under the medicaid program;
- (C) Conspires to commit a violation of subdivision (a)(1)(A), (a)(1)(B), or (a)(1)(D); or
- (D) Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money, or property to the state, or knowingly conceals, or knowingly and improperly, avoids, or decreases an obligation to pay or transmit money or property to the state, relative to the medicaid program.

Tenn. Code Ann. § 71-5-182(a)(1) (Supp. 2013) (prior versions of the above provisions for the relevant period are substantially similar to this current version). Any such person is liable to the

State of Tennessee for both treble damages and civil penalties “of not less than five thousand dollars (\$5,000) and not more than twenty-five thousand dollars (\$25,000)” per violation, subject to adjustment for inflation. *Id.*

39. The TMFCA defines “knowingly” to mean that a person, with respect to information:

- (1) Has actual knowledge of the information;
- (2) Acts in deliberate ignorance of the truth or falsity of the information;
or
- (3) Acts in reckless disregard of the truth or falsity of the information,
and no proof of specific intent to defraud is required.

Tenn. Code Ann. § 71-5-182(b). Accordingly, an individual who did not have actual contemporaneous knowledge of the falsity of claims or statements may nevertheless be liable under the TMFCA if the individual acted either in deliberate ignorance of or with reckless disregard to the claims’ or statements’ truth or falsity.

40. In this Complaint, whenever Plaintiff alleges that a defendant “knowingly” presented or caused to be presented a false claim, Plaintiff also alleges, in the alternative, that the defendant acted with “deliberate ignorance” or “reckless disregard” as those terms are used in the TMFCA.

FACTUAL BACKGROUND

MMi’s CORPORATE STRUCTURE AND BUSINESS MODEL

41. Since at least 2006, MMi has been in the business of operating pain management clinics and billing government healthcare programs for false or fraudulent medical services. At its peak, MMi operated approximately 18 pain management clinics throughout Tennessee (the

MMi Pain Clinics). Operation of MMi has been a de facto partnership between Defendants Mr. Kestner and Dr. Williams, with Mr. Kestner wielding the most control.

42. Mid-South Pain Management was the medical services arm of the business enterprise. It was the entity that owned and purportedly operated the MMi Pain Clinics. Dr. Williams was the named owner of Mid-South Pain Management. However, Dr. Williams exerted only limited control over the MMi Pain Clinics and the non-physician, mid-level healthcare providers who actually rendered services to patients (the MMi Providers), often yielding to the ultimate control of Mr. Kestner. Mr. Kestner routinely communicated directly with healthcare provider employees of Mid-South Pain Management about all aspects of their work and demanded to be informed of all matters related to providers employed by Mid-South Pain Management.

43. MedManagement, Inc. entered into a services contract with Mid-South Pain Management as early as 2006 and purported to provide all non-medical support for the MMi Pain Clinics, such as billing services and human resources services. In fact, MedManagement, Inc. and Mr. Kestner exerted ultimate control over the entire business enterprise, including the medical services arm. Pursuant to this agreement, Mid-South Pain Management initially paid 47% of its revenue, and beginning in April 2013, 45% of its revenue, to MedManagement, Inc., which was solely owned by Mr. Kestner.

44. In December 2013, Mr. Kestner formalized his total control over MMi by forming Pain MD. He merged all of MedManagement, Inc.'s assets into Pain MD, and Dr. Williams merged all of Mid-South Pain Management's assets into Pain MD. Mr. Kestner is the Chief Executive Officer, owner, and operator of Pain MD. He employs Dr. Williams as Pain MD's Medical Director.

45. Each MMi Pain Clinic is operated by an MMi Provider, typically an inexperienced nurse practitioner (NP) or physician assistant (PA). The MMi Providers treat the MMi Pain Clinics' patients.¹

46. The MMi business model is straightforward: 1) identify a patient population that will return for treatment regularly (for example, chronic pain patients who must return regularly to renew prescriptions for narcotic pain pills); 2) for the treatment of those patients, employ inexperienced NPs and PAs who are unlikely to recognize and challenge fraudulent treatment and billing practices; 3) train the NPs and PAs to perform certain procedures in a medically unnecessary volume and to fraudulently bill insurance programs for those procedures using the wrong reimbursement code; and 4) hire supervising physicians who do not properly supervise the NPs and PAs and therefore will be unlikely to detect, stop, or report the fraudulent behavior. Every MMi Pain Clinic follows this model.

PATIENT POPULATION

47. The MMi Pain Clinics and their providers purport to treat people suffering from chronic pain who seek an on-going regimen of pain medication. The specific diagnoses identified by the MMi Providers for their patients vary somewhat but typically include one or more of the following: myofascial pain syndrome, fibromyalgia, lumbago, spondylosis, or radiculopathy. However, most of the MMi Providers do not fully understand these diagnoses nor how to treat them.

¹ A list of the MMi Providers, the MMi Pain Clinics, and all associated National Provider Identification numbers is attached as Exhibit 1.

48. The MMi Providers prescribe the same course of treatment for virtually every insured patient: a narcotic pain pill prescription and superficial back injections. The pain patients in MMi's care return periodically, most often every month, for a new narcotic pain pill prescription. In exchange for the prescription, the insured patients must submit to superficial back injections, typically of a short-term numbing agent such as Lidocaine or Marcaine. The MMi Providers typically perform anywhere from 6-20, but as many as 50, injections on the insured patients at each visit. If the patient is a TennCare beneficiary, and many of them are, MMi bills the injections to the Medicaid program through an MCC.

MMi's INEXPERIENCED/INEPT PROVIDERS

49. Mr. Kestner personally hires the clinic providers (NPs and PAs) and attempts to ensure they are inexperienced and/or inept. Many of the NPs and PAs were recent graduates, and virtually no MMi Provider had any prior experience in pain management. Before Mr. Kestner assigns a new MMi Provider to operate one of the MMi Pain Clinics, the MMi Provider is trained by MMi to do nothing more than apply the MMi business model:

- a. Give every patient a narcotic pain pill prescription.
- b. Give every patient trigger-point injections.
- c. Document the injections as "TOIs," or "tendon origin insertions," and list them under CPT billing code 20551 on their superbills.²

² A "superbill" is a standard healthcare form with preprinted spaces for a provider to mark or otherwise identify diagnoses and services performed during a patient visit.

50. Mr. Kestner chose various NPs or PAs to serve as MMi Providers at various times. For many, their inexperience or ineptitude made them prime candidates for manipulation by Mr. Kestner. For example:

- a. MMi Provider Rona Justice née Addington was incapable of describing what a tendon was during an examination under oath.
- b. MMi Provider Tina Boyd used a simple “Trigger Points” smartphone app as a guide for her injections.
- c. MMi Provider George Lawless testified during an examination under oath that “[e]veryone ... from the owner down” told him that the patients were required to undergo injections, that he didn’t “know anything about these shots other than this is what they [MMi management] call these shots,” and that he simply “did what [MMi] asked me to do.”

POOR SUPERVISION

51. The MMi Providers work under the supervision of an MMi Supervising Physician. Each MMi Supervising Physician is assigned to supervise roughly four or five MMi Providers and corresponding MMi Pain Clinics. Under Tennessee law, in order for an NP or a PA to provide medical services, a supervising physician must review 20% of the provider’s patient charts every 30 days. Tenn. Comp. R. & Regs. §§ 0880-02-.18(8), 0880-06-.02(8). These circumstances result in the MMi Supervising Physician ordinarily being onsite one day a week at each clinic.

52. Mr. Kestner chose various doctors to serve as MMi Supervising Physicians at various times, including Dr. Alan Bachrach, Dr. Daniel Bernstein, Dr. Barry Bichon, Dr. Eric Fox,

Dr. Sidi Noor, and Dr. Allen Walker. The lack of competence of these supervising physicians is evidenced by, among other things:

- a. Dr. Walker is currently in prison for fraudulent acquisition of a controlled substance.
- b. Dr. Bernstein was issued a public letter of concern by the North Carolina Medical Board expressing concern about his poor supervision of an MMi NP and “other mid-level providers at several other pain practices.” A condition of the letter was that Dr. Bernstein disassociate himself from “any medical practice owned by [Defendant] Dr. Williams having a principle focus of chronic pain treatment or management.”
- c. Dr. Bachrach stated that his main objectives while supervising MMi Providers were:
 - i. to avoid being arrested,
 - ii. to keep his medical license, and
 - iii. to not completely lose the respect of the medical community.
- d. Dr. Fox was not comfortable filling in for one of the providers that he had been supervising because he was not confident that he knew how to administer the injections.
- e. Dr. Noor lost his medical license (since restored) for improperly prescribing narcotics.

PROCESSING OF CLAIMS

53. Among the forms used during each patient visit is a form known as a “superbill.” An example of a superbill is attached as Exhibit 2.³ During each patient visit, the MMi Provider records what she did to the patient on the superbill. For example, in the superbill example attached as Exhibit 2, MMi Provider Tina Boyd recorded that, on June 17, 2013, at the MMi Pain Clinic in Dyersburg, Tennessee, she performed an established patient office visit (CPT code 99213) and 36 tendon injections (CPT code 20551) on the patient. The superbills for virtually every MMi patient for nearly all visits are very similar, if not identical, to this example.

54. At the end of each business day, every MMi Provider FedExes all of the superbills from that day’s patient visits to MMi’s billing department. Once MMi’s billing department receives the superbills, the billing department clerks input the CPT codes and numbers of units into their billing software, adding billing modifiers regardless of whether they are justified, which then submits the claims to the MCC for reimbursement.

MMi CORPORATE CONTROL AND LEADERSHIP

55. Prior to the 2013 merger, Mr. Kestner and Dr. Williams were de facto partners in the MMi businesses to some extent. However, at all times, through direct ownership, contractual rights, and the force of his personality, Mr. Kestner has had ultimate control of MMi, Dr. Wil-

³ For privacy considerations, all patient-identifying information has been redacted from this exhibit and all other exhibits of superbills and claims data. Unredacted versions of the exhibits, which identify the patients by name and identification numbers, will be served on Defendants. Also, the unredacted superbills were originally produced by Defendants, with Bates labels on the bottom, and they were used as exhibits in the examinations under oath of four MMi Providers pursuant to Tenn. Code Ann. §§ 8-6-401 to -408.

liams, each MMi Pain Clinic, each of the MMi Providers, each of the MMi Supervising Physicians, and any additional personnel employed or contracted by MMi. Mr. Kestner makes all hiring and firing decisions regarding each individual MMi Provider and MMi Supervising Physician. Mr. Kestner determines each individual MMi Provider's and MMi Supervising Physician's compensation.

56. As the Medical Director of Pain MD, and also as the named owner of Mid-South Pain Management, Dr. Williams should have been implementing medical policy for the MMi Pain Clinics and guiding medical decision making. However, she allowed Mr. Kestner ultimate control over the medical decision making and medical policy for the MMi Pain Clinics and assisted him in executing the fraudulent schemes alleged in this Complaint. Emails show that Mr. Kestner—an attorney with no medical training—directly admonished providers when the exercise of their medical judgment interfered with business profit. Dr. Williams was aware of the admonishment and acquiesced to it.

57. Mr. Kestner personally monitors whether an MMi Provider is performing any injections on her patients and, if so, how many injections per patient visit, and he disciplines or rewards the MMi Provider accordingly.

58. Every individual MMi Provider and MMi Supervising Physician carries out their job for Mr. Kestner's behalf and at his direction. Each individual MMi Provider and MMi Supervising Physician is an agent or employee of Mr. Kestner. Every act alleged in this Complaint of any individual MMi Provider and MMi Supervising Physician is completed in the course of employment as an employee or in the course of agency as an agent.

59. Mr. Kestner, through his ownership of MedManagement, Inc. and Pain MD, was responsible for submitting claims for reimbursement to government healthcare programs and insurance companies for the services rendered by the MMi Providers. Mr. Kestner was fully aware of the billing practices and was warned by one MMi Provider that billing for the trigger-point injections as though they were tendon injections might be a “red flag” if a recovery audit contractor were to examine their billing practices looking for improper billing, but the practice continued.

SCHEMES OF FRAUD

60. Defendants’ fraud scheme is threefold, all designed to deceive TennCare into paying for medically unnecessary services at higher reimbursement amounts than should have been paid.

61. First, Defendants and the MMi Providers billed for the superficial back injections knowingly using, almost exclusively, an incorrect CPT code—CPT code 20551—that allowed them to bill for each individual injection given to every patient at each visit. If Defendants had used the correct CPT code, the billing would have been limited to one unit per patient visit, regardless of how many injections were performed.

62. Second, Defendants pressured the MMi Providers—through both punishment and reward—to perform a large number of the injections on each patient at each visit, without regard to whether the injections were medically necessary.

63. Third, Defendants appended Modifier 25 to 99.6% their claim submissions for office visits accompanying the injection procedures for established patients from May 2010 through December 2014, knowing that the MMi Providers did not perform separately identifiable

E&M services. Defendants' use of Modifier 25 allowed for reimbursement for the E&M services when the TennCare MCCs would otherwise have denied payment for those services.

64. The end result of Defendants' activities alleged in ¶¶ 61-63 was the knowing submission of false claims to government healthcare programs and/or the knowing making or use of false records or statements material to false claims to government healthcare programs.

65. The MMi Providers comprised only 6% of the providers in Tennessee who billed TennCare for CPT code 20551 from May 2010 through December 2014. Yet that 6% of providers were responsible for 90% of the total TennCare billing for CPT code 20551 in Tennessee during that time. Translated into dollars: 94% of providers in Tennessee billed TennCare a combined total of just over \$700,000.00, whereas the MMi Providers—the remaining 6% of providers—billed TennCare over \$7,400,000.00 for CPT code 20551.

**THE INJECTIONS ARE FALSELY AND FRAUDULENTLY
REFERRED TO AND SUBMITTED FOR BILLING UNDER CPT CODE 20551.**

66. Most skeletal muscles have an "origin" at one end and an "insertion" at the other end, with each end attached to bone via a tendon. A "single tendon origin/insertion" injection—the description for CPT code 20551 from the CPT Manual—is a procedure to diagnose and/or treat a tendon problem. Tendinitis (inflammation of a tendon) and tendinosis (degeneration of a tendon) are common tendon problems.

67. Tendon problems most often arise in the extremities because there is significant motion in the extremities. There is relatively less motion in the spine and therefore less stress directly on the associated tendons. Thus, tendinitis or tendinosis of the spine would be an unusual condition, and its diagnosis and treatment would likely require a spine specialist, such as a neurosurgeon or an orthopedic surgeon. An injection to diagnose and/or treat a tendon problem of

the spine would likely require imaging guidance (e.g., ultrasound or fluoroscopy) to ensure accurate placement of the needle because the muscles and other soft tissues along the spine, particularly in the lower back, occur in several layers.

68. Further, for therapeutic treatment, tendon injections usually include a corticosteroid, intended to treat inflammation. A therapeutic tendon injection would not consist of just an anesthetic.

69. An example of a procedure often billed with CPT code 20551 is an injection to treat tennis elbow. Tennis elbow (lateral epicondylitis) involves inflammation (tendinitis) or degeneration (tendinosis) of the tendon that attaches the main forearm muscle to the elbow. If that tendon becomes inflamed or degenerative, various alternative courses of treatment may be used. One course of treatment involves a corticosteroid injection. If the tendon is inflamed, the goal is to reduce the inflammation with an anti-inflammatory. An oral anti-inflammatory, such as ibuprofen, may work to reduce the inflammation, but it can sometimes be more effective to deliver the anti-inflammatory directly to the site of the damage: hence, an injection of a corticosteroid (the anti-inflammatory) around the inflamed tendon.

70. Tennis elbow injections, like tendon injections generally, are not performed in volume. Rather, tennis elbow injections are performed only one to three times within a six-month period for any one patient, after which other courses of treatment should be used if the patient's condition has persisted. Thus, CPT code 20551 is generally not limited in the number of units allowed for reimbursement, because there is an expectation that more than a few injections would rarely, if ever, be medically necessary.

71. A trigger point is a focal area of tenderness and/or spasm in skeletal muscle, often characterized by palpable knots in the muscle that fail to relax. Trigger points commonly accompany medical conditions such as myofascial pain syndrome, fibromyalgia, and various forms of back pain: Stimulating trigger points by touch or pressure generally evokes a painful response. Providers may use trigger-point injections—CPT codes 20552 and 20553—to treat these painful or taut areas. A medical provider identifies a trigger point by palpating the affected muscle to locate knots or points of tenderness, and treats by injecting a drug (usually a local anesthetic), saline, or just the needle itself into the trigger point. Imaging guidance for the injection is not ordinarily necessary.

72. It is not unheard of for a medical provider to perform multiple trigger-point injections in a single patient visit, but never in the volume that the MMi Providers perform them. If they are performed on one or two muscles, the claim must be submitted under CPT code 20552 (single or multiple trigger point(s), 1 or 2 muscles); if they are performed on more than two muscles, the claim must be submitted under CPT code 20553 (single or multiple trigger point(s), 3 or more muscles). Regardless of the actual number of injections, CPT codes 20552 and 20553—one or the other, not both—may be billed only one time per patient visit. MMi, Mr. Kestner, and Dr. Williams knew that trigger-point injections were limited to a single unit per patient visit for billing purposes.

73. The diagnoses commonly used by the MMi Providers—myofascial pain syndrome, fibromyalgia, lumbago, spondylosis, and radiculopathy—are not diagnoses of tendon problems. The treatment regimen commonly administered by the MMi Providers includes a narcotic pain pill prescription and superficial back injections. The MMi Providers identify the loca-

tions for injections by palpating the patient's back. The MMi Providers do not use imaging guidance to assist in administering the injections. The MMi Providers do not include a corticosteroid in the injections. Instead, the injections virtually always consist solely of a short-term anesthetic.

74. The superficial back injections the MMi Providers are performing are trigger-point injections rather than tendon injections.

75. By calling their injections "TOIs" or "tendon origin insertions" and listing the units of injections given under CPT code 20551, the MMi Providers and Defendants were able to subvert—through fraud—the billing unit limitations on trigger-point injections. For example, if an MMi Provider gives six injections to a patient at one patient visit and calls the injections trigger-point injections, she can list six units given on her superbill, but only one unit of 20552 or 20553 can be billed. If, however, she calls the injections "tendon origin insertions" and lists six units of 20551 on her superbill, all six units are billed and reimbursed. Likewise, if she gives 20 injections to a patient at one patient visit, calls them "tendon origin insertions" and lists 20 units of CPT code 20551, all 20 units are billed and reimbursed, as opposed to a single unit of CPT code 20552 or 20553 if she calls them trigger-point injections. For an average TennCare patient visit to an MMi Pain Clinic, that difference increased reimbursement for the injections more than six-fold, or approximately \$263 per patient visit. From May 2010 through December 2014, there were 27,562 TennCare patient visits for which MMi billed for CPT code 20551.⁴

76. The MMi Providers, with cursory independent review, and Dr. Williams, a physician, along with the MMi Supervising Physicians, either knew or should have known that the injections were not tendon injections, but rather trigger-point injections.

⁴ The complete TennCare claims data for these visits is voluminous. Although Defendants should have this data since they originally submitted it to TennCare, Plaintiff can provide Defendants the claims data upon request.

77. Dr. Williams knew that the claims submitted to government healthcare programs for reimbursement were false and benefitted financially from submission of the false claims.

78. At least one MMi Provider alerted Mr. Kestner that MMi may have difficulty justifying the procedures as tendon injections. At least one MMi Supervising Physician told Mr. Kestner multiple times that the MMi Providers were actually performing trigger-point injections. Mr. Kestner knew that the claims MMi submitted to government healthcare programs for reimbursement were false.

Specific claim submitted and paid under this scheme of fraud.

79. By way of example, on August 27, 2012, MMi Provider Ms. Justice purported to treat Patient A at the MMi Pain Clinic in Kingsport, Tennessee. The superbill for this encounter is attached as Exhibit 3. The TennCare claims data summary for this encounter is located on Exhibit 4. On the superbill, this scheme of fraud—calling the procedures by the wrong name—is reflected under “Procedures,” where Ms. Justice marked “26” next to “Inj Tendon Origin/Ins,” reflecting that Ms. Justice claimed to have performed 26 tendon injections on Patient A. The records for each visit for Patient A’s entire course of treatment were included as an exhibit to Ms. Justice’s November 7, 2014 examination under oath. The records show that Ms. Justice performed between 14 and 26 injections to treat Patient A at nearly every visit. Patient A’s course of treatment spanned a time period of nearly four years—July 16, 2009 to July 10, 2013—and included a total of 54 visits (an average of just over one per month). During that time, Patient A endured a total of 926 injections, for an average of 17.1 per visit. Patient A’s diagnoses at each visit included myofascial pain syndrome, lumbar and/or cervical spondylosis, radiculopathy, thoracic pain, and degenerative/displaced discs. Patient A was never diagnosed with a tendon problem. In

fact, at her examination under oath, Ms. Justice was incapable of describing what a tendon was. Patient A returned for the same treatment regimen every month for four years, but her condition at discharge was largely the same as when she began treatment. Her symptoms never improved, and her diagnoses remained the same. The patient records reflect that Ms. Justice, in treating Patient A, performed the injections in Patient A's back rather than in the extremities, even though a tendon problem in the back would be an unusual, significant abnormality. The records also reflect that Ms. Justice injected Lidocaine or Marcaine—short-term anesthetics—rather than a corticosteroid, even though therapeutic tendon injections usually contain corticosteroids and never consist of just an anesthetic. Further, because therapeutic tendon injections usually contain corticosteroids, it would be highly unusual—indeed dangerous—to perform 26 tendon injections in a single patient visit. There is nothing in the records indicating that Ms. Justice performed the purported tendon injections with imaging guidance, even though treating a tendon problem in the back would likely require such guidance. Each injection was billed as a tendon injection—CPT code 20551—but was really a trigger-point injection.

80. The above is only one example of a claim submitted under this scheme of fraud among the 27,562 patient visits for which MMi billed for CPT code 20551 from May 2010 through December 2014. It is representative of claims submitted by MMi for reimbursement for CPT code 20551 for procedures performed by every MMi Provider at every MMi Clinic.

**MR. KESTNER, WITH THE ACQUIESCENCE OF DR. WILLIAMS,
COERCED THE MMi PROVIDERS TO PERFORM PROCEDURES
IN A VOLUME THAT WAS NOT MEDICALLY NECESSARY.**

81. Mr. Kestner—who is a lawyer by education and is not medically trained—coerced the MMi Providers to perform the superficial back injections in high volumes. He did so despite

at least two MMi Providers protesting directly to him about the appropriateness of the injections for their patients. If the injections had actually been the tendon injections that MMi billed for, there would have been a risk of significant harm to the patients because therapeutic tendon injections usually contain a corticosteroid, which is not safe to inject 10, 20, or 50 times into a patient's back in one visit. Dr. Williams, as Medical Director and Mr. Kestner's partner, was complicit in this coercion.

82. Mr. Kestner has a concept he refers to as "OV-only," or "OVs" for short. It means a patient visit in which the MMi Provider only gives the patient a pain pill prescription and does not perform any other procedures. It is simply an office visit only, billed under CPT code 99213 for E&M services. The TennCare reimbursement for CPT code 99213, for the office visit for the patient to receive a new pain pill prescription, is approximately \$52. If an MMi Pain Clinic's patient comes in only for his periodic pain pill prescription and does not receive any additional procedures, MMi can only seek reimbursement of approximately \$52—one claim under CPT code 99213—for the patient visit. That situation is what Mr. Kestner refers to as an OV. As Mr. Kestner explains in an August 17, 2011 email to all MMi Providers:

[W]e have underperforming clinics that see a lot of patients but produce marginal revenue. This occurs for one reason and only one reason. They have a huge percentage of their patients who only get an office visit. Now while some patients only need an office visit (at our better clinics that is consistently about 8%) a good number of our patients are not being treated in the interventional methods we believe in.

This results in lots of OV treatments for which we average collecting \$52.00 which does not even come close to the cost of seeing a patient in our system. Given our overhead every \$52.00 office visit loses us approximately \$28.00. That's the math.

I hope that puts things in perspective. So stated another way ... the more OVs only you see the more you lose. (Of course we are talking about the insurance patients ... the revenue stream for self-pays is fixed in all cases).

Exh. 5. Hence, to be profitable to Mr. Kestner, an MMi Provider needs to perform additional procedures on her insured patients when they come in for their pain pill prescriptions. To Mr. Kestner, “better clinics” had nothing to do with appropriate care; he was concerned only about generating revenue with additional procedures. The procedure of choice was a medically unnecessary superficial back injection.

83. Mr. Kestner coerced the MMi Providers to perform additional procedures on their insured patients in many ways. For instance, Mr. Kestner sent weekly emails to all MMi Providers that ranked each provider’s clinic’s OV percentages against the other clinics’ OV percentages. An example of such an email is attached as Exhibit 6. A clinic’s OV percentages for the previous week represent the percentage of patients who received a pain pill prescription but no additional procedures. A high OV percentage meant that the provider was seeing a lot of patients without performing additional procedures. In Exhibit 6, for example, the MMi Pain Clinic in Spring Hill, Tennessee had an OV percentage of 28% for the previous week, meaning that the MMi Provider at that clinic did not perform additional procedures on 28% of her patients that week.

84. For Mr. Kestner, 28% is a high number of patients who only received prescriptions without submitting to additional procedures, principally superficial back injections. Mr. Kestner disapproved of high OV percentages. After Mr. Kestner described this concept of OV/OV-only to the MMi Providers and after he started emailing weekly rankings of the MMi Pain Clinics’ OV percentages, the OV percentages started to fall. Soon, some of the MMi Providers achieved OV percentages of 0%, meaning that not a single patient came in who did not also receive additional procedures. For example, in an October 10, 2011 email that ranked all MMi Providers on their OV percentages for the previous week, attached as Exhibit 7, eleven clinics had OV percentages of 0%. Mr. Kestner’s ever-moving target for the MMi Providers to meet was

to not let any more than 8% to 12% of the patients leave without performing additional procedures on them. The reductions in OV percentages evidence how successful Mr. Kestner was in pressuring providers to administer medically unnecessary back injections. There was no medical reason for the OV percentages to decrease; it was a direct response to Mr. Kestner's pressure.

85. The insured patients never receive just one superficial back injection. They receive injections in volume—typically anywhere from 6-20 injections at a time, but sometimes as many as 50 in one office visit. In fact, MMi billed—using CPT code 20551—for 298,358 injections performed by the MMi Providers on TennCare patients alone from May 2010 through December 2014.

86. Mr. Kestner refers to the volume of procedures performed on each patient as “Average Billing Per Patient.” Thus, average billing per patient means not just whether an MMi Provider is performing procedures on her patients, but how many procedures. The procedure of choice—and the most significant factor in average billing per patient—was a superficial back injection. Mr. Kestner tracked whether the MMi Provider was performing a lot of injections on each patient at each patient visit, or only performing a few. Different from the OV percentage metric, Mr. Kestner disapproved if an MMi Provider's average billing per patient was low. The higher an MMi Provider's average billing per patient, the more units of injections were billed and the more profits for Mr. Kestner, Dr. Williams, and MMi, but the more injections the patients endured in order to get their narcotic pain pill prescriptions.

87. In an August 30, 2011 email to all MMi Providers, Mr. Kestner explains this concept in more detail:

The following info ranks all clinics on the basis of average billing per patient for last week. This is very important info, because this is how we sustain our organization and pay our employees. **There is no more important data than this.** Furthermore, all future bonus programs are going to revolve

around bottom line profitability per clinic which is directly related to clinic billings. As a matter of fact, we are designing a 4th quarter bonus plan individualized for each clinic that will be directly tied to that clinic's billings.

For the past week, our providers ranged from a high of \$1,266.13 per patient to a low of \$388.80 per patient. The average billed per patient was \$766.43. We are profitable at the average and above. We are NOT profitable at the lower ranges. It's that simple.

We will continue to try and educate everyone about the necessity of understanding medical economics.

Exh. 8 (emphasis added).

88. Mr. Kestner pressured the MMi Providers to perform many injections on their insured patients by rewarding them and coercing them, through other MMi employees or, more often, directly, through emails, individual meetings, clinic rankings, and provider report cards. He interacted directly with the healthcare providers in this manner, personally shaping the way they practiced medicine, despite the fact that Mr. Kestner has no medical training and Dr. Williams was the owner of the clinics prior to the merger and the Medical Director thereafter.

89. At times, as part of their compensation package, the MMi Providers received a bonus or other reward if they had a high average billing per patient. Their clinic staff also received a smaller bonus at the same time.

90. More often, though, Mr. Kestner coerced the MMi Providers to perform a large volume of medically unnecessary injections on their patients. This coercion took many forms. One example is Mr. Kestner's weekly emails to the MMi Providers deriding them if their average billing per patient fell below what he felt was a profitable, satisfactory benchmark.

91. Mr. Kestner also coerced the MMi Providers to perform a large volume of medically unnecessary injections on their patients with threats. On occasion, if an MMi Provider's profitability began to fall, he would require the MMi Provider to travel to his office, where he

would more forcefully threaten the provider's job if she did not perform more injections on each of her patients.

92. Dr. Williams was aware of and acquiesced to Mr. Kestner's methods of pressuring the MMi Providers, even to the point of discussing which types of providers responded best to his methods.

93. Mr. Kestner's repeated pressure led the MMi Providers to abandon their own medical decision making in favor of Mr. Kestner's profit-driven—and not medically trained—decision making.

94. Dr. Williams, as a supervising physician and Medical Director, knew, was deliberately ignorant of, or acted in reckless disregard for the truth or falsity of the medical necessity of the claims submitted to government healthcare programs for reimbursement. Indeed, Dr. Williams was a participant in helping to execute this scheme and profited from it.

95. Mr. Kestner knew that the claims submitted to government healthcare programs for reimbursement were for procedures that were not medically necessary. At least two MMi Providers told Mr. Kestner that the injections were not medically necessary. At the very least, Mr. Kestner acted in reckless disregard for the truth or falsity of the medical necessity of the claims submitted to government healthcare programs.

Specific claim submitted and paid under this scheme of fraud.

96. By way of further example, on August 6, 2012, MMi Provider Jonathan White purported to treat Patient B at the MMi Pain Clinic in Winchester, Tennessee. The superbill for this encounter is attached as Exhibit 9. The TennCare claims data summary for this encounter is

located on Exhibit 4. On the superbill, this scheme of fraud—performing a large number of medically unnecessary injections on each patient at each patient’s visit—is reflected under “Procedures,” where Mr. White marks “x24” next to “Inj Tendon Origin/Ins.” The records for each visit for Patient B’s entire course of treatment were included as an exhibit to Mr. White’s October 31, 2014 examination under oath. The records show that Mr. White performed between 3 and 24 injections to treat Patient B at nearly every visit. Patient B’s course of treatment spanned a time period of five years—June 24, 2008 to June 17, 2013—and included a total of 80 visits (an average of more than one per month). During that time, Patient B endured a total of 760 injections. However, at the August 6, 2012 visit and 61 other visits during which he received injections, Patient B reported that nothing helped his pain other than medication. Patient B’s diagnoses at each visit include myofascial pain syndrome, spondylosis, radiculopathy, thoracic pain, and degenerative disc disease. Patient B was never diagnosed with a tendon problem. Patient B returned for the same treatment regimen every month for five years, but his condition at discharge was largely the same as when he began treatment. His symptoms never improved, and his diagnoses remained the same. Each injection was billed as a tendon injection—CPT code 20551—but was really a trigger-point injection. Regardless of how the injections were coded, they were in large measure medically unnecessary.

97. The above is only one example of a claim submitted under this scheme of fraud among the 27,562 patient visits for which MMi billed for CPT code 20551 from May 2010 through December 2014. It is representative of claims submitted by MMi for reimbursement for injections performed at every MMi Clinic by every MMi Provider.

**MMI FRAUDULENTLY APPENDS MODIFIER 25
TO ITS E&M CLAIM SUBMISSIONS.**

98. Generally, when a healthcare provider performs a procedure, all usual preoperative and postoperative care associated with the procedure is reimbursed through a single global payment. *See* CMS Pub. 100-04, Chapter 12, § 40.2. All services integral to accomplishing the procedure are considered bundled into that procedure. Therefore, reimbursement for all such services is included in the reimbursement rate that has been established for the comprehensive procedure code.

99. In some cases, separate payment may be made for separately identifiable E&M services provided on the same day of a procedure by the same provider who performed the procedure. In those instances where E&M services are necessary due to a different presenting issue, the provider may bill for a separate E&M code. Billing separately for E&M services during a single patient visit is permitted only when the patient's condition requires a significant, separately identifiable E&M service above and beyond the usual preoperative and postoperative care associated with the procedure performed. In order to signal to the payor that the E&M service is to be reimbursed in addition to the procedure code, the E&M code is submitted with "Modifier 25." In these circumstances, Modifier 25 should be added to the appropriate level of E&M service provided. *Id.* Without the appended Modifier 25, the E&M code, when submitted by the provider along with the procedure code, will not be reimbursed.

100. When Modifier 25 is used to seek reimbursement for a separate E&M service, both the medically necessary E&M service and the procedure must be appropriately and sufficiently documented by the provider in the patient's medical record to support the separate claim for service. *See* CMS Pub. 100-04, Chapter 12, § 30.6.6. For example, if an established patient

returns to an MMi Pain Clinic simply to receive a prescription refill and more trigger-point injections, the MMi Provider can bill only for the injection procedures, not for the E&M service associated with an office visit. However, if that same patient had also complained of pneumonia-like symptoms, MMi could have used Modifier 25 to bill for the office visit associated with the diagnosis and treatment of pneumonia, a service totally separate from the injection procedures.

101. After established patient office visits, the MMi Providers send the MMi billing office a superbill. MMi's billing office entity, which is totally owned and operated by Mr. Kestner, routinely appends Modifier 25 to virtually every established patient office visit in which units of procedure code 20551 are also submitted, thereby submitting claims for reimbursement for both the injection procedure and an E&M service. However, there is no separately identifiable E&M service provided when an MMi Provider performs injections on her established patients, and the E&M services should not be additionally reimbursed. Appending Modifier 25 to these claims constitutes falsely claiming that there was a separately identifiable E&M service provided when there was not.

102. Mr. Kestner and Dr. Williams knew the use of Modifier 25 was rarely justified, or they were deliberately ignorant or acted in reckless disregard of whether it was justified. On at least two occasions, MMi Providers alerted Mr. Kestner and Dr. Williams that an E&M service should not be billed along with the injection procedures. Mr. Kestner reprimanded those providers for objecting to this fraudulent practice.

Specific claim submitted and paid under this scheme of fraud.

103. By way of example, on November 12, 2012, MMi Provider Dennis McCraney purported to treat Patient C at the MMi Pain Clinic in Crossville, Tennessee. The superbill for

this encounter is attached as Exhibit 10. The TennCare claims data summary for this encounter is located on Exhibit 4. On the claims data summary, this scheme of fraud—adding Modifier 25 to support reimbursement for an E&M service (CPT code 99213) in addition to the procedure performed (CPT code 20551)—is reflected through the listing of “25” in the column identified as “First Modifier.” The records for each visit for Patient C’s entire course of treatment were included as an exhibit to MMi Provider Dan Seeley’s October 8, 2014 examination under oath.⁵ Patient C’s course of treatment spanned a time period of two and a half years—June 2, 2010 to February 11, 2013—and included a total of 32 visits (an average of one a month). The records reflect that the November 12, 2012 encounter was the twenty-ninth patient visit. The treatment regimen at nearly every visit was the same: a prescription for narcotic pain pills and superficial back injections. In fact, at the time of the November 12, 2012 visit, Patient C had received the same 12 superficial back injections and the same prescription refills at the 10 previous monthly visits. At each visit, Mr. McCraney instructed Patient C to return for another visit the following month. Patient C regularly returned for the same treatment regimen for two and a half years, but his condition at discharge was largely the same as when he began treatment. His symptoms never improved, and his diagnoses remained the same. The records reflect virtually identical symptoms, diagnoses, and plans of treatment for nearly all patient visits. The records do not evidence a significant, separately identifiable E&M service in addition to the injection procedures performed on November 12, 2012.

104. The above is only one example of a claim submitted under this scheme of fraud among the 25,619 patient visits for which MMi billed for an established patient office visit along

⁵ Mr. Seeley substituted for Mr. McCraney during one of Patient C’s visits.

with CPT code 20551, using Modifier 25, from May 2010 through December 2014. It is representative of claims submitted by MMi for reimbursement that use Modifier 25 for an established patient office visit, when injections were also performed, for every MMi Provider at every MMi Clinic.

LEGAL CLAIMS

COUNT ONE

(Presentation of false claims to the TennCare/Medicaid program)

105. The State of Tennessee re-alleges by incorporating herein by reference the allegations in ¶¶ 1-104.

106. By and through the acts described above, from May 2010 through December 2014, Defendants knowingly presented, or caused to be presented, false or fraudulent claims for payment under the TennCare/Medicaid program in violation of the TMFCA. Tenn. Code Ann. § 71-5-182(a)(1)(A).

107. Specifically, by submitting or causing to be submitted to TennCare MCCs claims for payment for a) injection procedures falsely coded under CPT code 20551, b) a medically unnecessary volume of injection procedures, and c) office visits that were not payable as such by appending Modifier 25 to the E&M billing codes, Defendants billed for and received funds they would not have been paid but for their fraudulent conduct.

108. Defendants knew the claims were false, or they deliberately ignored or recklessly disregarded whether they were false.

109. As a result of the false or fraudulent claims presented, or caused to be presented, by Defendants, the State has suffered damages, in an amount to be determined at trial, and is entitled to treble damages under the TMFCA, plus a civil penalty of \$5,000 to \$25,000 for each violation.

COUNT TWO

(Making or using false records or statements material to false claims under the TennCare/Medicaid program)

110. The State of Tennessee re-alleges by incorporating herein by reference the allegations in ¶¶ 1-104.

111. By and through the acts described above, from May 2010 through December 2014, Defendants knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims under the TennCare/Medicaid program in violation of the TMFCA. Tenn. Code Ann. § 71-5-182(a)(1)(B).

112. Specifically, by filling out, using, and/or submitting billing forms and/or patient records that contained false information about a) what services or procedures were performed, b) whether they were medically necessary, and c) whether Modifier 25 was justified, Defendants made, used, or caused to be made or used, false records or statements material to false or fraudulent claims under the TennCare/Medicaid program.

113. Defendants knew the superbills and/or patient records contained false information, or they deliberately ignored or recklessly disregarded whether the superbills and/or patient records were false.

114. As a result of the false records or statements made, used, or caused to be made or used by Defendants, the State has suffered damages, in an amount to be determined at trial, and

is entitled to treble damages under the TMFCA, plus a civil penalty of \$5,000 to \$25,000 for each violation.

COUNT THREE
(Unjust Enrichment)

115. The State of Tennessee re-alleges by incorporating herein by reference the allegations in ¶¶ 1-104.

116. By and through the acts described above, from May 2010 through December 2014, Defendants wrongfully received and retained the benefit of government monies paid from the TennCare program for a) procedures improperly coded as 20551, b) medically unnecessary amounts of those procedures, and c) office visits that were not payable, as they were not justified by a separately identifiable E&M service.

117. Defendants were unjustly enriched with those government monies from the TennCare program, which Defendants should not in equity and good conscience be permitted to retain, and which Defendants should account for and disgorge to Tennessee, in an amount to be determined at trial.

PRAYER FOR RELIEF

WHEREFORE, the State of Tennessee respectfully requests this Court grant the following relief against the defendants:

- a) Damages to be proved at trial, believed to exceed \$7,000,000.00, trebled as required by Tenn. Code Ann. § 71-5-182(a);
- b) Civil penalties up to the statutory amount as provided by Tenn. Code Ann. § 71-5-182(a) for each violation;
- c) Pre-judgment and post-judgment interest; and
- d) Any additional remedies the Court finds fair and just.

The State of Tennessee further respectfully requests a jury trial.

Respectfully submitted,



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MMi Pain Clinics

1. Cookeville Pain and Wellness Clinic
2. Lebanon Back Pain Clinic
3. McMinnville Pain Clinic
4. Middle Tennessee Pain Associates
5. Mt. Juliet Pain & Wellness
6. Murfreesboro Pain & Wellness
7. Pain Associates of North Tennessee
8. Pain Solutions of Cookeville
9. Pain Solutions of Gallatin
10. Pain Solutions of Greeneville
11. Cumberland Back Pain Clinic
12. Stones River Pain and Wellness Clinic
13. The Pain Center of Columbia
14. The Pain Center of Crossville
15. The Pain Center of Dyersburg
16. The Pain Center of Kingsport
17. The Pain Center of Lawrenceburg
18. The Pain Center of Portland