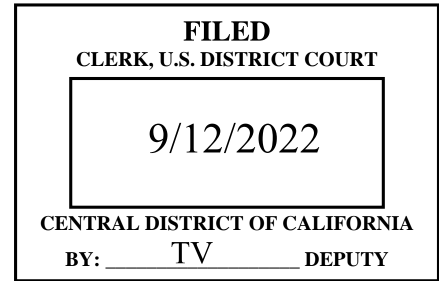

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA ex rel. LINCOLN ANALYTICS, INC.	Case No. 2:22-cv-06501-SVW-MAA
Plaintiffs,	COMPLAINT
v.	DEMAND FOR JURY TRIAL
GLOBAL INTEGRATED MEDICAL GROUP, INC., NORMITA SIERRA, JOHN MARK SISON,	FILED IN CAMERA AND UNDER SEAL PURSUANT TO 31 U.S.C. § 3730
Defendants.	

1 **I. INTRODUCTION**

2 1. *Qui tam* Plaintiff-Relator Lincoln Analytics, Inc., through its attorney, brings
3 this Complaint on behalf of the United States, and on its own behalf, pursuant to the Federal
4 False Claims Act, 31 U.S.C. §§ 3730 *et seq.*

5 **II. JURISDICTION AND VENUE**

6 2. This Court has subject matter jurisdiction pursuant to 31 U.S.C. § 3732(a) and
7 (b) and supplemental jurisdiction pursuant to 28 U.S.C. § 1359. The Court has personal
8 jurisdiction over the Defendants because Defendants transact business in this district, can be
9 found in this district, and committed acts within this district that violate 31 U.S.C. § 3729.

10 3. Venue is proper in this district under 31 U.S.C. § 3732(a) and 28 U.S.C. §
11 1391(b) and (c) because at all times relevant to this Complaint, Defendants regularly conducted
12 substantial business within this district.

13 **III. PARTIES**

14 4. Relator Lincoln Analytics, Inc. is a company that is incorporated in Delaware
15 and that uses data and investigation to detect health care fraud. Relator has personal knowledge
16 of the facts alleged in this Complaint, based on Relator's analysis of claims data and an
17 interview conducted on September 10, 2022 of Dr. Evelyn Basco, who is a medical director of
18 Defendant Global Integrated Medical Group, Inc. Relator is not aware of any "public
19 disclosure" in connection with the false claims alleged in this Complaint, as defined in 31
20 U.S.C. § 3730(e)(4)(A).

21 5. Relator qualifies as an "original source" under 31 U.S.C. § 3730(e)(4)(B)
22 because: (1) prior to any purported public disclosure, Relator voluntarily disclosed to the
23 Government the information on which allegations or transactions in this claim are based,

1 and/or (2) Relator has knowledge which is both direct and independent of any public
2 disclosures to the extent any may exist, and Relator voluntarily provided the information to
3 the Government before filing this action.
4 6. Global Integrated Medical Group, Inc. is a company that is incorporated in
5 California. According to a statement of information filed in August 2022 with the California
6 Secretary of State, Global Integrated Medical Group, Inc.'s principal address is 1535 W
7 Merced Avenue, Suite 202, West Covina, CA.
8 7. Defendant Global Integrated Medical Group, Inc. may also comprise other
9 corporate structures owned and operated by the same defendants, including Global Mobile
10 Medical Alliances, Inc., Mobile Physicians Medical Allied Group, Inc., and Apple Medical
11 Clinic, Inc., as described on the Global Integrated Medical Group website, https://global-
12 img.com (as accessed on September 11, 2022). The following screenshot from the Defendant's
13 website shows this relationship.

GLOBAL-IMG & AFFILIATES

14
15 8. Defendant Normita Sierra is the Chief Executive Officer of Global Integrated
16 Medical Group, Inc., Global Medical Alliances, Inc., Mobile Physicians Medical Allied
17 Group, Inc., and Apple Medical Clinic, Inc.
18 9. Defendant John Mark Sison is the Secretary and Chief Financial Officer of
19 Global Integrated Medical Group, Inc.

1 **IV. MEDICARE BACKGROUND**

2 10. In 1965, Congress enacted Title XVIII of the Social Security Act, 42 U.S.C. §
3 1395 *et seq*., known as the Medicare program. The Center for Medicare and Medicaid Services
4 ("CMS"), which is part of the Department of Health and Human Services ("HHS"),
5 administers Medicare.

6 11. Medicare is a health care benefit program within the meaning of 18 U.S.C. '
7 24(b). Medicare provides free or below-cost healthcare benefits to certain eligible
8 beneficiaries, primarily persons sixty-five years of age or older. Individuals who receive
9 Medicare benefits are often referred to as Medicare beneficiaries.

10 12. Medicare consists of four distinct parts, two of which are relevant here. Part A
11 provides for home health care, and Part B provides supplementary medical insurance for
12 physician services, outpatient services, and certain home health and preventive services.

13 13. Centers for Medicare and Medicaid Services, a federal agency within the United
14 States Department of Health and Human Services, administers the Medicare program. CMS
15 contracts with public and private organizations, usually health insurance carriers, to process
16 Medicare claims and perform administrative functions such as paying Part B claims from the
17 Medicare Trust Fund. The Medicare Trust Fund is a reserve of monies provided by the federal
18 government.

19 14. Enrolled providers of medical services to Medicare recipients are eligible for
20 reimbursement for covered medical services. By becoming a participating provider in
21 Medicare, enrolled providers agree to abide by the rules, regulations, policies, and procedures
22 governing reimbursement, to keep and allow access to records and information as required by

1 Medicare, and to not present or cause to be presented false or fraudulent claims for payment
2 to Medicare.
3 15. Medicare providers are obligated to understand and certify their compliance
4 with all applicable Medicare laws, regulations, and program instructions as a condition of
5 participation in Part B and as a condition of payment of Medicare reimbursements.
6 16. To seek payment from Medicare, providers of health care services to Medicare
7 beneficiaries seeking reimbursement under the program must submit a claim, which is a CMS
8 1500, with certain information regarding the Medicare beneficiary, including the beneficiary's
9 name, health insurance claim number, date the service was rendered, location where the service
10 was rendered, type of services provided, number of services rendered, the procedure code
11 (described further below), a diagnosis code, charges for each service provided, and a
12 certification that such services were personally rendered by that provider.
13 17. The American Medical Association has established certain codes to identify
14 medical services and procedures performed by physicians, which are collectively known as the
15 Current Procedural Terminology system. The CPT system provides a national correct coding
16 practice for reporting services performed by physicians and for payment of Medicare claims.
17 CPT codes are widely used and accepted by health care providers and insurers, including
18 Medicare and other health care benefit programs.
19 18. Given the volume of claims that are submitted to Medicare, Medicare relies on
20 providers to comply with Medicare requirements and trusts providers to submit truthful and
21 accurate certifications and claims. Typically, Medicare pays claims without any review of
22 supporting documentation, including medical records.

V. CARE PLAN OVERSIGHT SERVICES

19. According to the Medicare Benefit Policy Manual, Chapter 15, Section 30, Medicare allows for healthcare providers to bill for care plan oversight (CPO) services when they supervise services for a patient "receiving complex and/or multidisciplinary care as part of Medicare-covered services provided by a participating home health agency." Such services can include "regular physician development and/or revision of care plans; review of subsequent reports of patient status; review of related laboratory and other studies; communication with other health professionals not employed in the same practice who are involved in the patient's care; integration of new information into the medical treatment plan; and/or adjustment of medical therapy."

20. According to the Medicare Benefit Policy Manual, Chapter 15, Section 30, oversight services are eligible for payment only if all of 12 requirements are met, including the following:

- "The beneficiary must require complex or multi-disciplinary care modalities requiring ongoing physician involvement in the patient's plan of care;
- "The care plan oversight (CPO) services should be furnished during the period in which the beneficiary was receiving Medicare covered HHA or hospice services;
- "The physician who bills CPO must be the same physician who signed the home health or hospice plan of care;
- "The physician furnished at least 30 minutes of care plan oversight within the calendar month for which payment is claimed. Time spent by a physician's nurse or the time spent consulting with one's nurse is not countable towards the 30-mintue threshold. Low-intensity services included as part of other evaluation and management services are not included as part of the 30 minutes required for coverage.
- "Services provided incident to a physician's service do not qualify as CPO and do not count toward the 30-minute requirement;
- "The physician billing for CPO must document in the patient's record the services furnished and the date and length of time associated with those services."

1 21. According to the Medicare Claims Processing Manual, Chapter 12, Section
2 180.1, "Physicians may bill and be paid separately for CPO services only if all the criteria in
3 the Medicare Benefit Policy Manual, Chapter 15 are met."
4 22. According to the Medicare Claims Processing Manual, Chapter 12, Section 180,
5 CPO services "require recurrent physician supervision of a patient involving 30 or more
6 minutes of the physician's time per month … Implicit in the concept of CPO is the expectation
7 that the physician has coordinated an aspect of the patient's care with the home health agency
8 or hospice during the month for which CPO services were billed."
9 23. According to the Medicare Claims Processing Manual, Chapter 12, Section 180,
10 services "not countable toward the 30 minutes threshold … include, but are not limited to:
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- "Time associated with discussions with the patient, his or her family or friends to adjust medication or treatment;
- "Time spent staff getting or filing charts;
- "Travel time; and/or
- "Physician's time spent telephoning prescriptions into the pharmacist unless the telephone conversation involves discussions of pharmaceutical therapies."

18 24. Providers use CPT code G0181 to submit claims for care plan oversight.
19 **V. <u>THE FALSE CLAIMS ACT</u>**
20 25. Under the False Claims Act (31 U.S.C. § 3279 *et seq.*), any person who
21 "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or
22 approval" is liable to the United States Government for a civil penalty plus 3 times the amount
23 of damages which the Government sustained because of such person's acts.
24 26. Under 31 U.S.C. § 3730(b), any person may bring a civil action for a violation
25 of section 3729 for that person and for the United States government, and such action shall be
26 brought in the name of the United States government.

1 **VI. CPO SERVICES BILLED IN THE NAME OF DR. JOSE PILPA**

2 27. Dr. Jose Pilpa is registered as a Medicare provider. According to the website
3 for the Medical Board of California (last accessed on 9/11/22), Pilpa was issued a medical
4 license in California in 1984 and the license is "renewed and current."

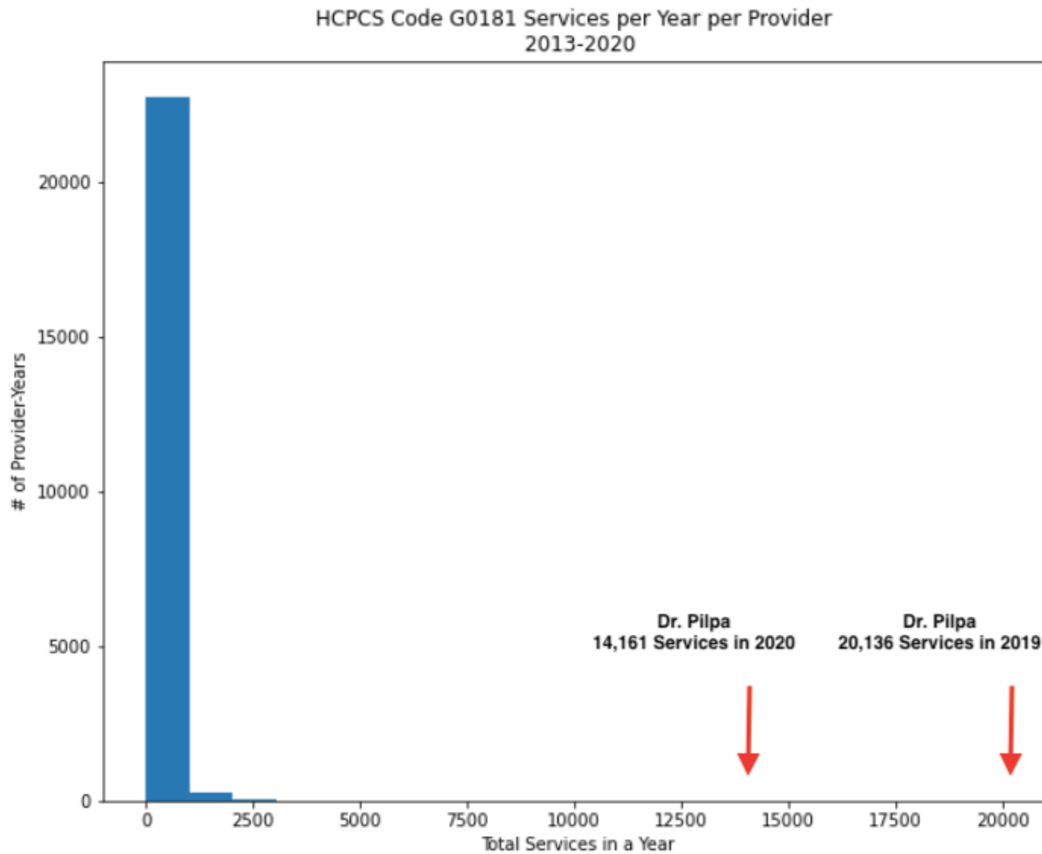
5 28. On information and belief, Dr. Pilpa was at relevant times a medical director of
6 Global Integrated Medical Group, Inc., which bills services relating to home health using his
7 name and NPI as rendering provider.

8 29. According to an analysis of claims data, Medicare was billed for millions of
9 dollars of claims in Pilpa's name beginning in 2019, with Medicare paying approximately $3.4
10 million on claims billed in in 2019 and approximately $2.3 million on claims billed in 2020.

11 30. According to an analysis of claims data, Medicare was billed for more claims
12 for care plan oversight services in Pilpa's name in 2019 and 2020 than for any other Medicare
13 provider in the United States. According to an analysis of claims data, Medicare was billed
14 for more than 20,000 care plan oversight services in Pilpa's name in 2019 and more than
15 14,000 care plan oversight services in Pilpa's name in 2020.

16 31. Figure 1 below shows how the billing for care plan oversight services in Pilpa's
17 name compares to other Medicare providers.

1 Figure 1: Services per Year per Provider, with Dr. Pilpa Indicated by Arrows



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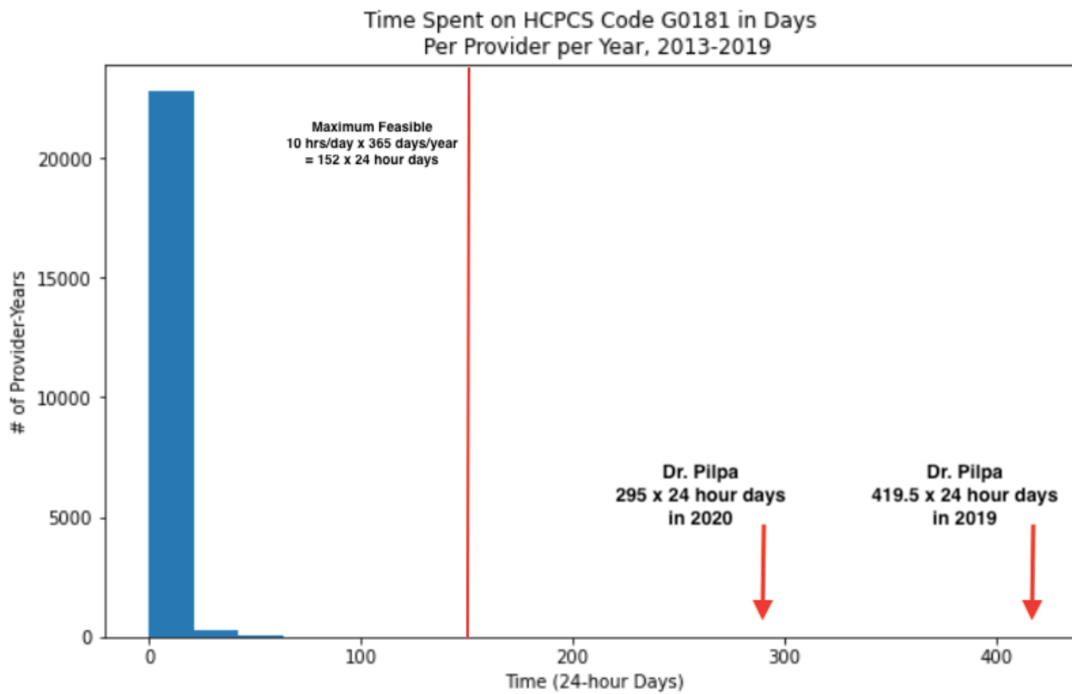
3 32. Each claim for care plan oversights requires the provider to spend at least 30
4 minutes per month on such services. Accordingly, Pilpa's claims for 2019, if true, would
5 indicate that he worked the equivalent of approximately 419.5 24-hour days in 2019 solely on
6 care plan oversight, which is physically impossible. Similarly, Pilpa's claims for 2020, if true,
7 would indicate that he worked approximately 295 continuous 24-hour days solely on care plan
8 oversight services.

9 33. Figure 2 below shows the distribution of Medicare providers' feasible time
10 allocation to care plan oversight. For reference, 365 10-hour days per year is equivalent to 152
11 continuous 24-hour days. Pilpa's claims greatly exceed that amount.

12

1 Figure 2:



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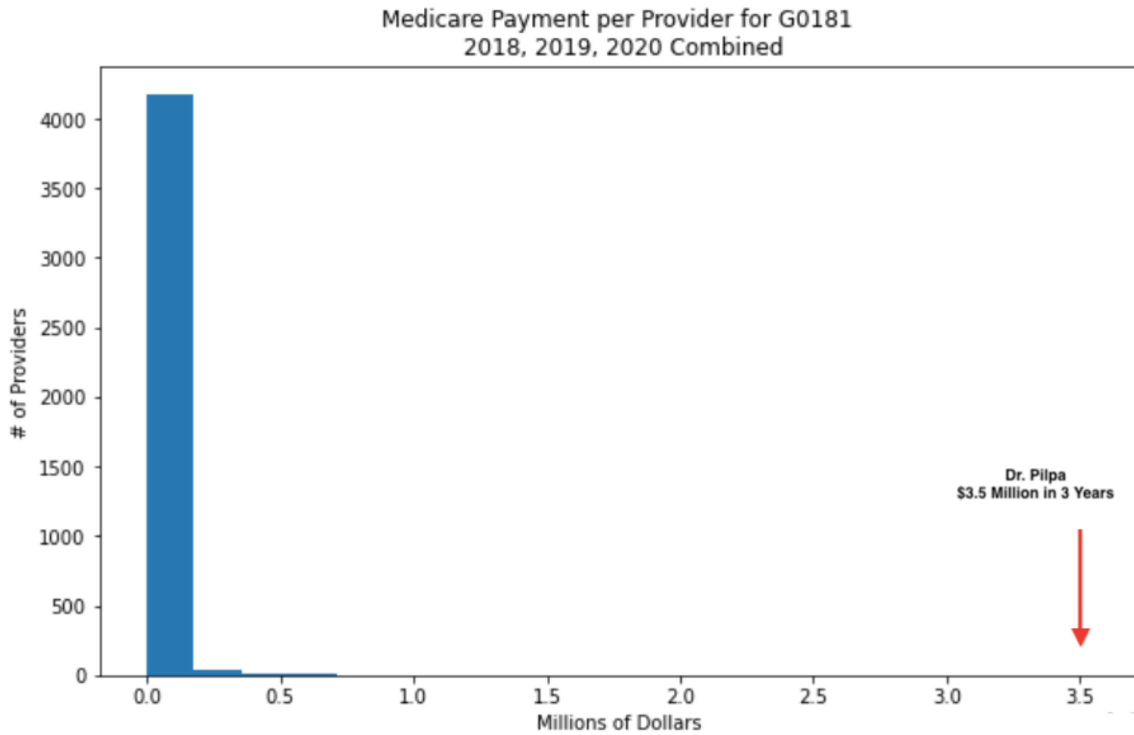
3 34. Medicare paid more on the claims billed in Pilpa's name to any other Medicare
4 provider for care plan oversight services in 2019 and 2020. Over the course of 2018, 2019 and
5 2020, Medicare paid approximately $3.5 million on care plan oversight services. On
6 information and belief, these payments went to Global Integrated Medical Group, Inc. By
7 contrast, the mean provider in 2018, 2019 and 2020 received approximately $22,503.97 for
8 care plan oversight services, and 99 percent of providers received $237,410.26 or less over
9 those three years. Pilpa, or companies billing in Pilpa's name, received more than 10 times
10 this amount.

1 Figure 3:



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3 35. On information and belief, Pilpa did not actually perform most if any of the care
4 plan oversight services that were billed to Medicare in his name. On information and belief,
5 Pilpa worked on a part-time basis at Global Medical Integrated Group, Inc., primarily
6 reviewing charts that were completed by nurse practitioners who actually visited and treated
7 patients. On information and belief, Pilpa did not regularly spend 30 minutes per month
8 providing services that would qualify for billing as care plan oversight services.

9 36. On information and belief, Defendant Global Medical Integrated Group, Inc.
10 billed Medicare for care plan oversight services in Pilpa's name based on automatic systems
11 to bill Medicare for care plan oversights for patients receiving home health services, regardless
12 of whether the patients or care met Medicare's requirements for CPO services.

1 37. On information and belief, Defendant Normita Sierra oversaw the improper
2 billing of care plan oversight services in Pilpa's name and caused improper claims for care
3 plan oversight services in Pilpa's name to be submitted to Medicare, resulting in improper
4 payments on such claims.
5 38. On information and belief, Defendant John Mark Sison caused improper claims
6 for care plan oversight services in Pilpa's name to be submitted to Medicare, resulting in
7 improper payments on such claims.
8 **VII. CPO SERVICES BILLED IN THE NAME OF DR. EVELYN BASCO**
9 39. Dr. Evelyn Basco is registered as a Medicare provider. She was issued a medical
10 license in California.
11 40. Dr. Basco was at relevant times a medical director of Global Integrated Medical
12 Group, Inc., which bills services relating to home health using her name and NPI as rendering
13 provider. In that capacity, she primarily reviewed charts that were completed by nurse
14 practitioners who actually visited and treated patients. She did not work full-time at Global
15 Integrated Medical Group, Inc.
16 41. An analysis of Medicare claims data shows that Medicare was billed for
17 approximately 9,891 care plan oversight care plan oversight services in Basco's name in 2018;
18 7,328 care plan oversight services in 2019; and 9,259 care plan oversight services in 2020.
19 These numbers are infeasible, due to the amount of time each takes. They are also statistical
20 outliers, higher than every other physician billing Medicare nationwide, except Dr. Pilpa.
21 42. Because of the excessive billing for Care Plan Oversight, Medicare paid
22 approximately $2.86 million for care plan oversight services billed in Basco's name from
23 2017-2020.

1 43. On information and belief, Basco did not actually perform most if any of the
2 care plan oversight services that were billed to Medicare in her name. Basco worked on a part-
3 time basis at Global Medical Integrated Group, Inc., primarily reviewing charts that were
4 completed by nurse practitioners who actually visited and treated patients. Basco did not
5 regularly spend 30 minutes per month providing services that would qualify for billing as care
6 plan oversight services.

7 44. On information and belief, Defendant Global Medical Integrated Group, Inc.
8 billed Medicare for care plan oversight services in Basco's name based on automatic systems
9 to bill Medicare for care plan oversight services for patients receiving home health services,
10 regardless of whether the patients or care met Medicare's requirements for CPO services.

11 45. On information and belief, Defendant Normita Sierra oversaw the improper
12 billing of care plan oversight services in Basco's name and caused improper claims for care
13 plan oversight services in Basco's name to be submitted to Medicare, resulting in improper
14 payments on such claims.

15 46. On information and belief, Defendant John Mark Sison caused improper claims
16 for care plan oversight services in Basco's name to be submitted to Medicare, resulting in
17 improper payments on such claims.

18 47. On information and belief, in addition to false claims for CPO services,
19 Defendants billed Medicare improperly for home visits that were performed by nurse
20 practitioners and that were billed as if physicians had rendered the visits and as if the visits
21 were more complicated than they actually were, in noncompliance with Medicare billing rules
22 and leading to overpayments.

1 **VIII. CAUSE OF ACTION**

2 48. Relator repeats and realleges the preceding paragraphs as if fully set forth
3 herein.

4 49. All Defendants, in reckless disregard or deliberate ignorance of the truth or
5 falsity of the information involved, or with actual knowledge of the falsity of the information,
6 knowingly presented or caused to be presented, and may still be presenting or causing to be
7 presented, to the United States of America false or fraudulent claims for payment or approval,
8 in violation of 31 U.S.C. § 3729(a)(1)(A).

9 50. As a result of Defendants' actions, as set forth above, the United States of
10 America has been, and may continue to be, damaged.

11 **VIII. PRAYER FOR RELIEF**

12 51. WHEREFORE, *Qui Tam* Plaintiff, Lincoln Analytics, Inc., for the United
13 States, and for itself, prays as follows and request:

14 a. That the Court enter judgment against the Defendants in an
15 amount to be determined at trial, equal to three times the amount
16 of damages the United States Government has sustained because
17 of Defendants' actions, plus a civil penalty for each action in
18 violation of 31 U.S.C. § 3729, and the costs of this action, with
19 interest, including the costs to the United States Government for
20 its expenses related to this action;

21 b. That in the event the United States Government intervenes in
22 this action, Lincoln Analytics, Inc. be awarded 25% of the
23 proceeds of the action or the settlement of any such claim;

c. That in the event the United States Government does not proceed with this action, Lincoln Analytics, Inc. be awarded 30% of the proceeds of this action or the settlement of any such claim;

52. That the Court award an alternate remedy or other such other relief as is appropriate.

53. That Lincoln Analytics, Inc. be awarded all costs, attorneys' fees, and litigation expenses of this action.

54. That the United States Government and Lincoln Analytics, Inc. receive any and all other relief, both at law and in equity, to which they may reasonably appear entitled.

IX. JURY DEMAND

55. Pursuant to Federal Rule of Civil Procedure 38(d), Relator demands a trial by jury for all claims and issues so triable.

Dated: September 12, 2022

Respectfully submitted,

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