RETURN DATE: AUGUST 27, 2019

STATE OF CONNECTICUT, *Plaintiff*	:	SUPERIOR COURT
	:	
v.	:	JUDICIAL DISTRICT OF HARTFORD
	:	
THERAPY UNLIMITED, LLC AND CATHERINE RISIGO WICKLINE *Defendants*	:	JULY 17, 2019

COMPLAINT

The Plaintiff, the State of Connecticut, represented by William Tong, Attorney General for the State of Connecticut, alleges the following against the Defendants, Therapy Unlimited, LLC (Defendant TU), and Catherine Risigo Wickline (Defendant Wickline).

SUMMARY

The Plaintiff, the State of Connecticut, brings this complaint under the Connecticut False Claims Act (Act), Conn. Gen. Stat. §§ 4-274 *et seq.* The complaint alleges that during the period beginning at least as early as January 2014 and continuing through the present, the Defendants have engaged in pervasive and illegal schemes to bill Connecticut's Medicaid program and its state employee health plan and collect millions of dollars by: (1) inflating on claims for reimbursement the actual time that Defendant TU's occupational therapists (OTs) and physical therapists (PTs) purportedly spent delivering healthcare services to Medicaid patients and patients covered by the State Employee Health and Retirement Plan (State Plan); and (2) using unlicensed staff to deliver some of these services. The complaint further alleges that the Defendants knowingly created and submitted, and/or caused to be created and submitted, false claims for reimbursement for OT and PT for far more treatment time than the therapists actually provided to indigent and/or disabled Connecticut residents who receive health care through

Connecticut's Medicaid program, and to patients covered by the State Plan. This complaint further alleges that the Defendants knowingly created and submitted, and/or caused to be created and submitted, false claims for reimbursement purportedly for OT and PT services, even though the Defendants knew that these claims were for services performed by unlicensed staff, including a fitness trainer and a former intern. The State of Connecticut seeks treble damages, civil penalties, and other relief available under the Act for the Defendants' illegal conduct.

The Attorney General also brings this complaint on behalf of the Connecticut Department of Social Services (Department or DSS) under the common law of breach of contract. The complaint further alleges that Defendant TU breached its duty arising under its provider enrollment agreement with the DSS to submit claims and receive payment only for services provided by OTs and PTs who are enrolled as providers in the Connecticut Medical Assistance Program (CMAP), which includes Connecticut's Medicaid program (sometimes referred to as HUSKY). The complaint alleges that the Defendant TU received substantial payments from the DSS as reimbursement for the claims submitted to the CMAP for services provided to its Medicaid patients purportedly by providers enrolled in the CMAP, but who were not in fact enrolled in the CMAP.

PARTIES

1. The Plaintiff is the State of Connecticut, represented by William Tong, Attorney General. The Attorney General brings Count One and Count Two of this action, alleging violations of the Act, pursuant to the authority granted to him by the Act. The Act authorizes the Attorney General to bring a civil action in the name of the state if he finds that a person has violated the Act. Conn. Gen. Stat. § 4-276. The Attorney General brings Count Three of this

complaint as the legal representative of the DSS, alleging that Defendant TU breached its provider enrollment agreement with the DSS.

2. Defendant Wickline is an occupational therapist licensed by the State of Connecticut. She resides in Watertown, Connecticut, and works in Oakville, Connecticut. Defendant Wickline is an enrolled provider in the CMAP.

3. Defendant TU is a limited liability company organized under Connecticut law. Defendant TU is an independent provider of OT and PT located in Oakville, Connecticut. Defendant Wickline is the sole owner of TU. Defendant TU is an enrolled provider in the CMAP.

4. During the relevant time period for the events described in this complaint Defendant TU transacted business in the State of Connecticut under its name and under the tradenames "Jumpstart" and "Jumpstart Fitness and Therapy Network."

5. The relevant time period for the causes of action set forth below is at least as early as January 2014 through the present.

LEGAL AND PUBLIC POLICY BACKGROUND

6. The Act provides in relevant part, with respect to claims for payment under a state-administered health or human services program, that any person who:

(a) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; Conn. Gen. Stat. § 4-275 (a)(1); or

(b) knowingly makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim; Conn. Gen. Stat. § 4-275 (a)(2);

is liable to the State of Connecticut for relief, including civil penalties and treble damages. Conn. Gen. Stat. § 4-275 (b).

6. For the purposes of the Act, "state-administered health or human services program" means all programs administered by the Department, and/or administered for the State Plan. Conn. Gen. Stat. § 4-274(7).

7. For the purposes of the Act: "knowing" and "knowingly" means that a person, with respect to information: (a) has actual knowledge of the information; (b) acts in deliberate ignorance of the truth or falsity of the information; or (c) acts in reckless disregard of the truth or falsity of the information, without regard to whether the person intends to defraud. Conn. Gen. Stat. § 4-274(1).

8. The CMAP, including Medicaid, is a state-administered health or human services program. Conn. Gen. Stat. § 4-274(7). The CMAP pays enrolled healthcare providers for health care benefits provided to program recipients.

9. Medicaid is a joint federal-state program that provides health care benefits for certain groups of persons, including the indigent and disabled. The federal Medicaid statutes set forth the minimum requirements for state Medicaid programs to qualify for federal funding. 42 U.S.C. § 1396a.

10. The DSS Commissioner is authorized to promulgate regulations necessary to administer the CMAP, including the State of Connecticut's Medicaid program. Regulations of Connecticut State Agencies (R.C.S.A.) § 17b-262-523(13).

CMAP PROVIDER ENROLLMENT AND PARTICIPATION

11. The CMAP requires all providers who wish to participate in the CMAP to enroll and enter into an agreement with the DSS, known as a provider enrollment agreement. This agreement, which is periodically updated, remains in effect for the duration specified in the agreement. The provider enrollment agreement specifies conditions and terms that govern the

program which the provider is mandated to adhere to in order to participate in the program and to receive payment. R.C.S.A. § 17b-262-524.

12. During the relevant time period Defendant TU was enrolled in the CMAP as a billing provider for OT and PT, and was a party to a provider enrollment agreement with the DSS (TU Provider Agreement). Defendant Wickline executed the TU Provider Agreement on behalf of Defendant TU.

13. During the relevant time period Defendant Wickline was enrolled in the CMAP as an independent therapist (and more particularly, as an occupational therapist), and was a party to a provider enrollment agreement with the DSS that she executed (Wickline Provider Agreement; the TU and Wickline Provider Agreements collectively referred to as the Provider Agreements). *See* R.C.S.A. § 17b-262-631(12) (defining occupational therapist as one type of independent therapist).

CMAP PAYMENT REQUIREMENTS

14. The Provider Agreements obligate Defendants TU and Wickline to submit to the DSS only those claims seeking reimbursement for covered goods and services that are documented as being: (a) medically necessary and are actually provided to the Medicaid beneficiaries in whose name the claims are made; and (b) for compensation that the provider is legally entitled to receive. Provider Agreements, Para. 15.

15. The Provider Agreements also require the Defendants to comply with all laws, regulations, and DSS enrollment requirements. Provider Agreements, Paras. 1 and 2.

16. In order to receive payment for covered goods and services provided to CMAP beneficiaries, Connecticut regulations require providers, among other things, to meet and maintain all DSS enrollment requirements. R.C.S.A. §§ 17b-262-632 (b) and 17b-262-524.

17. Connecticut regulations expressly condition payment to the provider upon compliance with DSS enrollment requirements, and all applicable laws and regulations. R.C.S.A. §§ 17b-262-522, 17b-262- 524, 17b-262-526.

18. In particular, Connecticut regulations expressly condition payment to providers of OT and PT: (a) upon compliance with all applicable licensing requirements; and (b) upon all healthcare providers having a valid provider enrollment agreement on file with the DSS. R.C.S.A. §§ 17b-262-632 (a) and (d).

19. Connecticut regulations and the Provider Agreements require that any overpayment for CMAP goods or services, defined as the excess over the payment authorized, or any payment owed to the DSS because of a violation due to abuse or fraud, shall be payable to the DSS. R.C.S.A. § 17b-262-533; R.C.S.A. § 17b-262-523(18); Provider Agreements, Para. 23.

20. The DSS may recover any overpayments which the provider does not repay by bringing an action against the provider. Provider Agreements, Para. 23.

ENROLLMENT IN ANTHEM'S NETWORK AS A PROVIDER TO STATE EMPLOYEES COVERED UNDER THE STATE PLAN

21. The State Plan is a state-administered health or human services program. Conn. Gen. Stat. § 4-274(7). The State Plan reimburses healthcare providers who are enrolled in the provider networks of health insurance companies, such as Anthem, that administer the health care benefits provided to state employees, retirees, and their eligible family members who are covered under the State Plan.

22. Defendant TU is enrolled as a participating provider in Anthem's provider network for the State Plan. Anthem manages a provider network for state employees, retirees, and their eligible family members who are covered under the State Plan, and administers the claims for reimbursement for services submitted by healthcare providers. The State Plan is self-

insured, meaning that the State of Connecticut is the ultimate payer for these claims, including the claims submitted by TU purportedly for services delivered to state employees and retirees and their eligible family members who are covered under the State Plan.

THE FALSE CLAIMS SCHEMES – A PERVASIVE PATTERN OF FRAUDULENT BILLING

BILLING CLAIMS FOR OT AND PT SERVICES

23. OTs and PTs submit the requisite healthcare service information and billing information necessary for billing personnel to generate claims for reimbursement for their services. The claims are submitted to public and private payers. Among the information provided by OTs and PTs is the appropriate CPT (Current Procedural Terminology) code that describes the services that they provided to the patient on the date of service.

24. Third-party payers, such as the CMAP and the State Plan, reimburse these claims based on the reimbursement amount assigned by the respective payers to each CPT code. CPT codes may be for untimed or timed services.

25. OT and PT services for established patients are reimbursed using timed CPT codes. Timed CPT codes reimburse the provider for the period of time that the performing provider spends with the patient delivering the service that is described for the particular CPT code selected by the performing provider.

26. The same timed CPT codes apply for both OT and PT services. For the CPT codes for established OT and PT patients, one unit may be billed for each 15 minute period spent delivering services to a patient.

27. For example, an OT or a PT that spends 45 minutes with a patient doing therapeutic activities would bill three units of CPT code 97530, the code for therapeutic activities. If during a 45 minute session with a patient the OT or PT performs more than one

type of service, the therapist would bill by apportioning the actual time spent by the therapist among the appropriate CPT codes. Thus, if during a 45 minute session the therapist spends: (a) a total of fifteen minutes doing therapeutic activities – CPT Code 97530; (b) fifteen minutes doing manual therapy – CPT Code 97140; and (c) fifteen minutes doing therapy procedures – CPT Code 97110, the therapist would record one unit for each code, for a total of three units.

The Submission of Grossly Inflated Claims to the CMAP and the State Plan

28. Defendant TU employs occupational and physical therapists to provide OT and PT services primarily to children.

29. Defendant TU's OTs and PTs usually spent 45 minutes with their Medicaid patients, and one hour with their State Plan patients.

30. Rarely did the sessions exceed these lengths. More commonly the OT and PT sessions lasted less than 45 minutes. When a child had back-to-back OT and PT sessions, each session would typically last for only one-half hour, because children generally had difficulty with longer back-to-back sessions.

31. After each session the therapists entered the CPT codes and the number of units for each CPT code in their treatment notes, and submitted the notes to TU's biller. The biller submitted claims to the CMAP and to Anthem for each patient, for the number of units for each CPT code as set forth in each therapist's treatment notes.

32. Initially Defendant TU billed the CMAP and the State Plan by submitting claims for one timed unit for a single CPT code for each 15 minute period that its therapists spent providing services to the patient. This practice changed at the end of 2013.

33. Beginning at least as early as January 2014, Defendant Wickline directed TU's OT and PT therapists and billing personnel to bill at least two of the following three CPT codes

for every patient treatment session: 97110 (therapeutic procedure), 97140 (manual therapy techniques), and 97530 (therapeutic activities).

34. During 2014 Defendant TU billed the CMAP, for each 45 minute session, for two CPT codes, in varying patterns. These patterns included billing two units (.5 hour) for one code together with eight units (2 hours) for another code. This pattern of billing resulted in Defendant TU billing the CMAP for 2.5 hours of services, even though Defendant TU's OTs and PTs actually spent 45 minutes or less with the patient.

35. During 2014 Defendant TU also billed the State Plan, for each one hour session, for two CPT codes, in varying patterns. These patterns included billing three units (.75 hour) for one code and six units (1.5 hours) for a second code. This pattern of billing resulted in Defendant TU billing the State Plan for 2.25 hours of services, even though Defendant TU's OTs and PTs actually spent one (1) hour or less with the patient.

36. By mid-2015, Defendant Wickline mandated that regardless of the actual time that the OT and PT therapists spent with their patients, for every date of service (patient visit) the therapists had to bill: (a) for CMAP patients, a total of ten (10) 15 minute units of service (for a total of 2.5 hours), by allocating two units, four units, and four units among the three CPT codes, and (b) for patients with private insurance, including the State Plan's Anthem coverage, 12 to 16 units (3 to 4 hours), by allocating the units among the three CPT codes.

37. Defendant Wickline required TU's therapists to bill these excessive units for every single patient, without regard to their specific condition, the amount or type of OT/PT therapy that was actually provided to the patient, or the actual length of time spent with the patient. Consistent with this "one-size-fits-all" approach, some of the OT and PT therapists had sticky notes posted in the work stations where they prepared their treatment notes in order to remind

themselves to include in their treatment notes, for every CMAP patient, "2-4-4" as the number of units to be billed among the three CPT codes, for a total of two and one-half hours.

38. In keeping with Defendant Wickline's mandate to her staff, following each session with a patient the therapists entered the three CPT codes and the excessive number of units of time for each CPT code in their treatment notes, and submitted their notes to TU's biller. The biller used the CPT codes and the number of units contained in these treatment notes to bill the CMAP and the State Plan.

39. The therapists employed by Defendant TU typically had little or no experience working at other OT/PT practices and, thus, had no experience in how to properly bill OT/PT services using CPT codes. They did not know that each unit corresponded to 15 minutes of service. The therapists were simply told by Defendant Wickline that they had to bill the prescribed number of units for each of the three CPT codes, and they followed those orders.

40. If the therapist billed less units than 2-4-4 (or 3-3-6 for State Plan patients) for the three CPT codes, the biller would return the treatment note to the therapist with an instruction to bill at the higher reimbursement level. Defendant Wickline repeatedly told therapists that they had to provide TU's billing staff with the prescribed number of units or else TU would not be able to remain in business.

41. Defendant Wickline threatened a TU billing employee that if she did not follow Wickline's instruction to submit claims with the inflated charges, the employee and others would lose their jobs as a result. Wickline told the employee that the inflated claims were how TU was going to make money.

42. During the time period when TU was only billing one or two CPT codes for each CMAP or State Plan patient, Defendant Wickline told this employee that she should add another

CPT code and additional timed units for all claims submitted to government and commercial payers, and see if the payers paid such claims.

43. In March 2017 Defendant Wickline, and certain TU administrative staff and therapists, attended a seminar devoted to billing and coding OT/PT services. The seminar instructor stated to the seminar attendees that for timed CPT codes for OT and PT services, only a single 15 minute unit may be billed for services delivered for one 15 minute period of therapy.

44. During this seminar, the instructor made it clear to those attending from TU that TU's practice of billing multiple timed units for multiple CPT codes for a single 15 minute period was improper.

45. Following the seminar certain TU therapists questioned Defendant Wickline about the propriety of her directive to bill two and one-half hours of time for CMAP patients even though they were only spending from thirty to forty-five minutes with the patient. Wickline responded that TU could not remain open if the TU therapists submitted billing information with the number of timed units that corresponded with the actual time that the therapists spent with their patients.

46. After the seminar some therapists reduced the number of timed units that they included with the billing information, because they were concerned that they were participating in potentially illegal billing. Defendant Wickline and a senior therapist informed therapists that they could not all reduce the number of units billed at the same time because it would look like something was wrong with the way that they had been billing previously.

47. Following the seminar Defendant TU still continued billing the CMAP and the State Plan for far more time than the actual time that TU's therapists spent with their patients, despite the seminar instructor's clear statement that TU's billing methodology was improper.

48. Thereafter a second expert advised Defendant Wickline that Defendant TU's billing methodology was improper.

49. From October 2017 through mid-January 2018, Defendant TU employed a medical billing specialist who was an experienced certified professional coder. By letter dated January 12, 2018, the billing specialist told Wickline that she had "checked a couple of [treatment] notes to match to the amount of units that are being billed and they are not supported. I can no longer bill out the way it is being done. I value my position at [TU] and would like to make the necessary changes so it can be done correctly. Please advise so we may move forward."

50. Defendant Wickline never responded to the letter, and on January 23, 2018, the medical billing specialist resigned.

The Submission of Claims for Services Delivered By Unlicensed Staff

51. Connecticut regulations make clear that the CMAP reimburses only for services provided by licensed providers. R.C.S.A. §17b-262-524(a)(1); R.C.S.A. §17b-262-632 (a).

52. Defendants agreed in their Provider Agreements to comply with all applicable state and federal regulations. Provider Agreements, Para. 2.

53. Nevertheless, Defendants submitted or caused to be submitted thousands of claims to the CMAP for services provided to patients by unlicensed staff.

54. For example, a fitness trainer, who held neither an OT license nor a PT license, conducted exercise classes at TU with groups of children.

55. Sometimes the fitness trainer's name appeared as the OT therapist on the patients' treatment notes. Defendant TU's appointment schedules showed that these children were scheduled for separate appointments with the fitness trainer.

56. Even though the fitness trainer worked with groups of children, Defendant TU submitted claims for reimbursement for nearly three hundred separate individual sessions to the CMAP at the higher reimbursement rate for individual OT. TU submitted these claims to the CMAP, purportedly for OT services provided by a licensed OT, but in fact the claims were for fitness groups run by a fitness trainer.

57. Group OT services provided to patients by a licensed OT are billed to the CMAP at the lower group rate, not the higher rate applicable only to individual OT therapy sessions. Nevertheless, the services provided by a fitness trainer are not covered services and are not reimbursed by the CMAP.

58. Defendant TU also billed the CMAP for OT services for more than 1,400 therapy sessions provided by a former OT student who interned at TU, but had never obtained his OT license.

59. The unlicensed former intern's name was identified on numerous treatment notes as the treating therapist. In addition, he was designated in TU's records as the case manager for a number of patients, and appointment logs indicated that he was scheduled for appointments with patients.

60. Defendant Wickline told an administrative staff member that TU would continue billing for the services of the unlicensed staff members, notwithstanding the fact that they were unlicensed.

61. Defendants regularly received reimbursements from the CMAP and, through Anthem, from the State Plan, by check or electronic funds transfer as reimbursement for the claims that the Defendants submitted or caused to be submitted for OT and PT services purportedly provided to TU's CMAP clients and those clients covered under the State Plan.

62. From at least as early as January 2014 through the present, Defendants systematically and knowingly submitted false and fraudulent claims to the DSS and the State Plan for OT and PT services by: (a) grossly inflating the actual time that TU's OTs and PTs delivered therapy services to CMAP patients and patients covered under the State Plan, and (b) using unlicensed personnel to deliver certain treatment services.

63. During this time period the DSS reimbursed Defendant TU a total of more than $3.46 million for the false claims submitted to the CMAP.

64. During this time period the State Plan reimbursed Defendant TU a total of more than $364,000 for the false claims submitted to the State Plan.

65. Defendant Wickline used the reimbursements that she fraudulently obtained from the CMAP and the State Plan to support a lavish lifestyle. For example, Defendant Wickline used the funds paid to Defendant TU's financial accounts to pay for designer clothing from Prada; designer jewelry from David Yurman; trips to Portugal, the Caribbean and skiing; country club dues; purchases from art galleries; spas; and Tony Robbins life improvement seminars.

Services Provided By Unenrolled Providers

66. DSS regulations state that in order to participate in and receive payment from the CMAP, providers must be enrolled in the CMAP and have valid executed provider enrollment agreements on file with the DSS. R.C.S.A. §17b-262-524(a)(2) and (3); R.C.S.A. § 17b-262-632 (a) (2) and (4). Defendant TU's Provider Agreement obligated TU to comply with these and all other pertinent state regulations. TU Provider Agreement, Para. 2.

67. Many of Defendant TU's OTs and PTs were not enrolled as providers in the CMAP when they provided services to CMAP patients.

68. Defendant TU nevertheless billed and received payment from the CMAP for thousands of claims for OT and PT services that were performed by providers who were not enrolled as providers in the CMAP.

COUNT ONE – Presentation of False Claims - Conn. Gen. Stat. § 4-275(a)(1)

69. The allegations of paragraphs 1 — 68 of this complaint are incorporated herein as allegations of Count One as if fully set forth herein.

70. Pursuant to the Act, Connecticut General Statutes § 4-275(a)(1), no person shall knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval under a healthcare services program administered by the DSS or the State Plan.

71. From January 2014 through the present, Defendants knowingly engaged in a long-term pattern and practice of causing to be submitted or submitting false claims to the DSS and to the State Plan for services that the Defendants, their agents and/or employees purportedly performed, but which claimed services greatly exceeded the services actually performed.

72. From January 2014 through the present, Defendants knowingly engaged in a long-term pattern and practice of causing to be submitted or submitting false claims to the DSS and to the State Plan for services that the Defendants, their agents and/or employees purportedly performed using licensed therapists, but which in fact were performed by unlicensed staff.

73. From January 2014 through the present, Defendants knowingly presented or caused to be presented, to a state-administered health or human services program, false or fraudulent claims for payment.

74. By virtue of the false or fraudulent claims made or caused to be made by Defendants, the State has suffered damages.

75. Defendants are liable to the state for treble damages under the Act, in an amount to be determined at trial, plus a civil penalty of $5,500 to $11,000, or as adjusted from time to time by the Federal Civil Penalties Inflation Adjustment Act Improvement Act of 2015, 28 U.S.C. § 2461, for each false claim presented or caused to be presented by the Defendants.

COUNT TWO – Causing False Records or Statements to Be Made or Used - Conn. Gen. Stat. § 4-275(a)(2)

76. The allegations of paragraphs 1 — 75 of this complaint are incorporated herein as allegations of Count Two as if fully set forth herein.

77. Pursuant to the Act, Connecticut General Statutes § 4-275(a)(2), no person shall knowingly make, use or cause to be made or used, a false record or statement material to a false or fraudulent claim under a state-administered health or human services program.

78. The Defendants caused TU's OTs, PTs, billing personnel and other staff to create false records of the services that they rendered and the time that they spent delivering such services to their patients, which records were material to the false or fraudulent claims that TU submitted to the DSS and to the State Plan.

79. The State has suffered damages due to the Defendants' knowingly making, using or causing to be made or used, false records or statements material to false or fraudulent claims under a state-administered health or human services program.

COUNT THREE – Breach of Contract

80. The allegations of paragraphs 1 — 79 of this complaint are incorporated herein as allegations of Count Three as if fully set forth herein.

81. The TU Provider Agreement establishes a duty for Defendant TU to comply with all laws, regulations, and DSS enrollment requirements. TU Provider Agreement, Paras. 1 and 2.

82. State regulations and the TU Provider Agreement provide that in order for providers such as Defendant TU to receive payment from the DSS, the providers who delivered the services for which Defendant TU submitted claims, must have valid provider agreements on file with the DSS. R.C.S.A. §§ 17b-262-522, 524, and 526; R.C.S.A. §§ 17b-262-632.

83. The TU Provider Agreement also requires the Defendant TU to pay to the DSS any payment from the CMAP for goods or services which represents an excess over the appropriate payment, or any payment owed to the DSS because of a violation due to abuse or fraud. TU Provider Agreement, Para. 23.

84. From 2013 through the present, Defendant TU received substantial payments from the DSS as reimbursement for the claims submitted to the CMAP for services provided to its CMAP patients purportedly by providers (a) enrolled in the CMAP with valid provider agreements on file with the DSS and (b) who were duly licensed to provide covered OT and PT services. In fact these providers were not enrolled in the CMAP and had never entered into provider agreements with the DSS.

85. The DSS has complied with all of its material obligations required of it under the terms and conditions of the TU Provider Agreement.

86. Defendant TU failed to fulfill the condition precedent to its right to payment, namely that all providers of the services for which it submitted claims for reimbursement to the CMAP (a) be enrolled in the CMAP, (b) be duly licensed to provide OT and PT therapy services, and (c) have valid provider enrollment agreements on file with the DSS.

87. Defendant TU breached its duties under the Provider Agreement to submit claims to the DSS only for services provided by providers enrolled in the CMAP who have valid provider agreements on file with the DSS.

88. The TU Provider Agreement authorizes the DSS to recover all overpayments it made to Defendant TU, including without limitation all reimbursements which it paid to Defendant TU for claims for services delivered by such unenrolled providers. TU Provider Agreement, Para. 23.

89. The State has suffered damages as a result of Defendant TU's breach of the TU Provider Agreement.

DEMAND FOR RELIEF

WHEREFORE, the STATE OF CONNECTICUT requests the following relief:

1. Pursuant to Conn. Gen. Stat. § 4-275(b), a civil penalty of not less than five thousand five hundred dollars or more than eleven thousand dollars, or as adjusted from time to time by the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended by the Federal Civil Penalties Inflation Adjustment Act Improvement Act of 2015, 28 U.S.C. § 2461, for each violation of the Act;

2. Pursuant to Conn. Gen. Stat. § 4-275(b), three times the amount of damages that the State of Connecticut sustained because of the acts of Defendant TU and Defendant Wickline.

3. Pursuant to Conn. Gen. Stat. § 4-275(b), costs of investigation and prosecution of this action;

4. Money damages; and

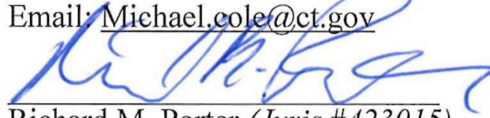
5. Such other relief as is just and equitable to effectuate the purposes of this action.

The amount, legal interest or property in demand is $15,000 or more, exclusive of interest or costs.

Dated at Hartford, Connecticut, this 17th day of July, 2019.

PLAINTIFF
STATE OF CONNECTICUT

BY: WILLIAM TONG
ATTORNEY GENERAL



Michael E. Cole (Juris #417145)
Assistant Attorney General
Chief, Government Program Fraud Department
55 Elm Street, P.O. Box 120
Hartford, CT 06141-0120
Tel: (860) 808-5040/Fax: (860) 808-5033
Email: Michael.cole@ct.gov

Richard M. Porter *(Juris #423015)*
Assistant Attorney General
55 Elm Street, P.O. Box 120
Hartford, CT 06141-0120
Tel: (860) 808-5040/Fax: (860) 808-5391
Email: rick.porter@ct.gov