IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA, the **COMMONWEALTH OF VIRGINIA**, and the **STATE OF NEW JERSEY** *ex rel.* **CHRISTINE HODGE**, *Plaintiffs,* v. **URGENT CARE HOLDINGS, INC. d/b/a MEDEXPRESS URGENT CARE**, *Defendant.*	**No. 2:21-cv-7595-SDW-LDW** **JURY TRIAL DEMANDED**

FIRST AMENDED COMPLAINT AND DEMAND FOR JURY TRIAL

Plaintiff and *qui tam* Relator Christine Hodge ("Relator"), by and through her undersigned counsel Brown, LLC, alleges of personal knowledge as to her observations and actions, and on information and belief as to all else, as follows:

I.
PRELIMINARY STATEMENT

1. Defendant operates a chain of urgent care clinics in more than a dozen states, including New Jersey, Virginia and West Virginia. During the pandemic caused by the novel COVID-19 virus, urgent care clinics have played an important role administering COVID-19 tests and identifying those infected with the virus.

2. Seeking to capitalize on the increased demand for testing, Defendant fraudulently billed each test to Medicare and Medicaid as an office visit,[1] for which Defendant falsely documented a higher level of medical service than was actually provided.

[1] In this First Amended Complaint, "office visit" is a medical coding term that refers to the Evaluation and Management (E/M) service provided by a medical professional and billed separately to payors. The term as used here

3. Specifically, Defendant coded and billed COVID-19 tests provided to patients who had zero symptoms, no known exposure to the virus, and tested negative for the virus, as Level 3 Evaluation and Management (E/M) office visits, even though the patient-provider encounters lasted for just a few minutes and the patients were sent home without follow-up care. These visits should have been billed as Level 2 or not billed at all.

4. In a stark contrast showing that the office visits were superfluous, asymptomatic patients whose COVID tests were paid for by their employer did not receive any office visit. Therefore, whether a patient received an office visit or not was dictated not by medical necessity, but by who was footing the bill.

5. This glaring discrepancy in care, based solely on who was paying for the services, reveals what Defendant has known all along: that office visits for COVID screening tests for asymptomatic, non-exposed patients are medically unnecessary.

6. Defendant knowingly billed these upcoded and unnecessary office visits to, and received payments from, Medicare and Medicaid.

7. Relator brings this *qui tam* action on behalf of the United States of America under the False Claims Act, 31 U.S.C. §§ 3729 *et seq.* (the "FCA") to recover treble the damages sustained by, and civil penalties and restitution owed to, the United States as a result of Defendant's fraud.

8. Relator also brings this action on behalf of the Commonwealth of Virginia under the Virginia Fraud Against Taxpayers Act, Va. Code Ann. §§ 8.01-216.1 *et seq.*, to recover treble the damages sustained by, and civil penalties and restitution owed to, the Commonwealth as a result of Defendant's fraud.

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should not be confused with its more colloquial meaning, referring generally to anyone visiting the office of a provider regardless of the services provided.

9. Relator also brings this action on behalf of the State of New Jersey under the New Jersey False Claims Act, N.J. Stat. Ann. §§ 2A:32C-1 *et seq*., to recover treble the damages sustained by, and civil penalties and restitution owed to, the State as a result of Defendant's fraud.

II.
JURISDICTION AND VENUE

10. This Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331, because this action is brought for violations of the False Claims Act, 31 U.S.C. §§ 3729 *et seq*. The Court has jurisdiction over the state-law claims pursuant to 31 U.S.C. § 3732(b).

11. The Court has personal jurisdiction over Defendant because Defendant can be found in, is licensed to transact and does transact business in, this District, and has carried out their fraudulent scheme in this District.

12. Venue is proper in this District pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391(b)(2), because Defendant can be found in, and transacts or has transacted business in this District, and the events and omissions that give rise to these claims have occurred in this District.

13. The original Complaint was filed within the time period prescribed by 31 U.S.C. § 3731(b), Va. Code Ann. § 8.01-216.9, and N.J. Stat. Ann. § 2A:32C-11.

III.
NO PUBLIC DISCLOSURE;
MATERIAL AND INDEPENDENT INFORMATION

14. Relator makes the allegations in this First Amended Complaint based on her own knowledge, experience and observations.

15. Relator is the original source of the information on which the allegations herein are based, and voluntarily disclosed such information to the Government before filing this action.

16. There has been no public disclosure, relevant under 31 U.S.C. § 3730(e), Va. Code Ann. § 8.01-216.8 or N.J. Stat. Ann. § 2A:32C-9(c), of the "allegations or transactions" in the

original Complaint or this First Amended Complaint. Alternatively, to the extent that any such public disclosure has been made, Relator possesses information that is independent of and materially adds to any allegations that may have been publicly disclosed.

IV.
THE PARTIES

A. Government Plaintiffs

17. Relator brings this action on behalf of Plaintiff the United States of America. At all times relevant to this First Amended Complaint, the United States, acting through the Centers for Medicare & Medicaid Services ("CMS"), has reimbursed Defendant for claims they submitted for services that were medically unnecessary and/or upcoded.

18. Relator also brings this action on behalf of Plaintiff the Commonwealth of Virginia, which has reimbursed Defendant for services that were medically unnecessary and/or upcoded through Virginia's Medicaid program.

19. Relator also brings this action on behalf of Plaintiff the State of New Jersey, which has reimbursed Defendant for services that were medically unnecessary and/or upcoded through New Jersey's Medicaid program.

B. Relator Hodge

20. Relator Christine Hodge is a citizen of the United States and, at all relevant times, has been a resident of Bedford County, Virginia. From approximately March 2020 to September 2021, Relator worked as a physician assistant at Defendant's urgent care clinics in the Virginia cities of Roanoke, Salem, Christiansburg, Harrisonburg, Staunton, Danville, Martinsville, and Lynchburg.

C. Defendant Urgent Care Holdings, Inc. d/b/a MedExpress Urgent Care

21. Defendant Urgent Care Holdings, Inc. d/b/a MedExpress Urgent Care, is a Delaware corporation with a principal business address of 423 Fortress Boulevard, Morgantown, WV 26508.

22. Defendant owns and operates over 190 urgent care clinics in over a dozen states, including New Jersey, Virginia, and West Virginia.

23. Defendant's clinics are organized under numerous subsidiary corporate entities.

24. As relevant here, MedExpress Urgent Care New Jersey, P.C. and MedExpress Urgent Care – Northern New Jersey PC are the subsidiaries responsible for Defendant's clinics in New Jersey. MedExpress Urgent Care P.C. – Virginia is the subsidiary responsible for Defendant's clinics in Virginia. MedExpress Urgent Care, Inc. – West Virginia is the subsidiary responsible for Defendant's clinics in West Virginia.

V.
STATUTORY & REGULATORY FRAMEWORK

A. The Federal False Claims Act and Analogous State Laws

25. The FCA, 31 U.S.C. §§ 3729 *et seq.*, establishes liability for any "person" (natural or corporate) who, *inter alia*:

(A) "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval," 31 U.S.C. § 3729(a)(l)(A); or

(B) "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim," *id.* § 3729(a)(l)(B).

26. "Knowing" is defined by the FCA to include "deliberate ignorance of the truth" or "reckless disregard of the truth." *Id.* § 3729(b)(1).

27. The FCA defines "claim" to include any request for money that:

> is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government—
>
> (I) provides or has provided any portion of the money or property requested or demanded; or
>
> (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded….

Id. § 3729(b)(2)(A)(ii).

28. For each false claim or other FCA violation, the statute provides for the assessment of treble damages, plus a civil penalty. *Id*. § 3729(a)(1)(G).[2]

29. The FCA provides for payment of a percentage of the United States' recovery to a private individual who brings suit on behalf of the United States (the "Relator") under the FCA. *See id*. § 3730(d).

30. The Virginia Fraud Against Taxpayers Act, Va. Code Ann. §§ 8.01-216.1 *et seq*., and the New Jersey False Claims Act, N.J. Stat. Ann. §§ 2A:32C-1 *et seq*., impose nearly identical prohibitions and liability on any "person" (natural or corporate) who obtains funds from the state governments through false or fraudulent conduct. *See* Va. Code Ann. § 8.01-216.3; N.J. Stat. Ann. § 2A:32C-3.

31. Like their federal counterparts, the Virginia Fraud Against Taxpayers Act and the New Jersey False Claims Act provide for treble damages plus a civil penalty for each false claim or other violation. *See* Va. Code Ann. § 8.01-216.3; N.J. Stat. Ann. § 2A:32C-3.

[2] 31 U.S.C. § 3729(a)(1)(G) provides a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, Pub. L. No. 104-410, 104 Stat. 890 (1990), *amended by* the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, Pub. L. No. 114-74, 129 Stat. 599 (2015); *see* 28 U.S.C. § 2461 note. Currently, the minimum per-claim penalty is $11,803 and the maximum is $23,607. *See* 86 F.R. 70740, 70740-46 (Dec. 13, 2021).

32. The Virginia Fraud Against Taxpayers Act and the New Jersey False Claims Act permit a private individual to bring a civil *qui tam* action on behalf of the Commonwealth of Virginia and the State of New Jersey, respectively, and provide for payment of a percentage of the proceeds of the action to that individual. Va. Code Ann. § 8.01-216.7; N.J. Stat. Ann. § 2A:32C-7.

B. The Medicare Program

33. The Medicare program pays for certain healthcare services provided to certain segments of the population. Entitlement to Medicare is based on age, disability, or affliction with end-stage renal disease. *See* 42 U.S.C. §§ 1395 *et seq.*

34. The federal Department of Health and Human Services ("HHS"), through CMS, administers the Medicare program.

35. The Medicare program has four parts. As relevant here, Medicare Part B covers medical services rendered by eligible medical professionals in the office or outpatient setting. 42 U.S.C. §§ 1395j to 1395w-5.

36. CMS enters into agreements with healthcare providers to participate in the Medicare program. Individuals or entities who are participating providers in Medicare may seek reimbursement from CMS for services rendered to patients who are Medicare beneficiaries.

37. To enroll as an authorized participant in Medicare, providers are required to make the following certification:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to me or the organization [applying for enrollment]. The Medicare laws, regulations, and program instructions are available through the Medicare Administrative Contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations and program instructions….

Medicare Enrollment Application: Physicians and Non-Physician Providers, CMS-855I, at 23.[3]

38. A provider's compliance with applicable Medicare program rules and regulations is material to the government's decision to pay and its subsequent payment of claims. In order to be reimbursable by Medicare, services must be medically necessary. *See* 42 U.S.C. § 1395y(a)(1)(A); 42 C.F.R. § 411.15(k).

39. After enrolling in Medicare, to receive payment under Medicare Part B, a provider must submit claims to the appropriate Medicare Administrative Contractor or "MAC"[4] using a CMS-1500 form.[5] The CMS-1500 form requires the provider to identify the services for which reimbursement is sought using a five-digit Current Procedural Terminology ("CPT") or Healthcare Common Procedural Coding System ("HCPCS") code. The amount of Medicare reimbursement is based on the lesser of (a) the actual charge or (b) the fee for the appropriate CPT or HCPCS code on a standardized fee schedule established by the Secretary of HHS.

40. The CMS-1500 form also requires the provider to make the following certification:

> In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete … [and] 4) **this claim … complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment** …

Form CMS-1500 at 2 (emphasis added).

41. A provider may also submit the electronic equivalent of this claim form, which contains a substantially similar certification.

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[3] *Available at* https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855i.pdf (last accessed Mar. 10, 2022).

[4] A MAC is a private insurer awarded a geographic jurisdiction to process medical claims for Medicare beneficiaries. At all relevant times, the A/B MAC for Virginia and West Virginia was Palmetto GBA, LLC, and the A/B MAC for New Jersey was Novitas Solutions, Inc.

[5] *Available at* https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf (last accessed Mar. 10, 2022).

42. CMS guidance as to electronic claims submission is found in Chapter 24 of the Medicare Claims Processing Manual (the "Claims Manual"). Among other things, the guidance specifies the minimum content of the enrollment form that a local MAC may use to sign up providers to submit claims electronically. Per the Claims Manual, such an enrollment form must contain, and the enrolling provider must acknowledge, at least the following statements:

> The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' A/B MACs ….
>
> * * *
>
> 7. That it will submit claims that are accurate, complete, and truthful;
>
> * * *
>
> 12. That it will acknowledge that all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the Medicare program, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal law; [and]
>
> * * *
>
> 14. That it will research and correct claim discrepancies[.]

Claims Manual, Ch. 24 § 30.2.

43. The submission of such a certification, if false, is a violation of the FCA. 31 U.S.C. § 3729(a).

44. Each such false certification is a separate violation of the FCA.

C. The Medicaid Program

45. Congress enacted Medicaid under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.*

46. Medicaid is a jointly funded cooperative venture between the federal and state governments to provide healthcare to certain groups, primarily the poor and the disabled. *See* 42 C.F.R. §§ 430.0 *et seq.*

47. Under the Medicaid program, the United States, through CMS, pays a specified percentage of each state's Medicaid program expenditures, known as the Federal Medical Assistance Percentage. *See* 42 U.S.C. § 1396d(b).

48. For example, New Jersey's Medicaid Program is administered by the New Jersey Division of Medical Assistance and Health Services (DMAHS), and Virginia's Medicaid Program is administered by the Virginia Department of Medical Assistance Services (DMAS).

49. To enroll in the Medicaid program, each provider must sign a Medicaid provider agreement with their respective states. Enrolled providers must agree to abide by the rules, regulations, policies and procedures governing claims for payment, and to keep and allow access to records and information as required by Medicaid.

VI.
DEFENDANT'S FRAUD

A. Compliance with E/M coding rules; Materiality to Government's decision to pay

50. In the CY2020 Physician Fee Schedule final rule, CMS adopted the American Medical Association's ("AMA") newly revised guidelines for office/outpatient E/M visit codes, which went into effect January 1, 2021.[6]

51. The AMA's new guidelines allow providers to select an E/M level based on either time spent by the provider, or the complexity of medical decision making (MDM).[7]

52. As relevant here, CPT codes 99203 and 99213 represent a Level 3 E/M Visit for new and established patients, respectively.

[6] *See* 84 F.R. 62847-48 (Nov. 15, 2019) (CY2020 PFS final rule); *see also* 85 F.R. 84548 (Dec. 28, 2020).
[7] *See* https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management (last accessed Mar. 10, 2022).

53. If time is used to determine the E/M level, codes 99203/99213 are appropriate if the provider spends 30 to 44 minutes with a new patient, or 20 to 29 minutes with an established patient.[8]

54. If MDM is used to determine the E/M level, codes 99203/99213 are appropriate if the MDM level is "low."

55. The MDM level is comprised of following three elements:

(1) Number and complexity of problems addressed
(2) Amount and complexity of data reviewed
(3) Risk of complications or morbidity from additional testing or treatment

56. To qualify for a particular MDM level, two of the three elements must be met or exceeded.

57. An MDM level of "low," which corresponds to a Level 3 code (99203 or 99213), requires the following elements:

(1) Element 1: Number and Complexity of Problems Addressed
- 2 or more self-limited or minor problems; or
- 1 stable chronic illness; or
- 1 acute, uncomplicated illness or injury

(2) Element 2: Amount and/or Complexity of Data to be Reviewed (Must meet at least one category below)
- Category 1: Tests and documents (Any combination of 2 from the following)
  1. Review of prior external note(s) from each unique source
  2. Review of the result(s) of each unique test
  3. Ordering of each unique test
- Category 2: Assessment requiring an independent historian(s)

(3) Element 3: Risk of Complications and/or Morbidity or Mortality of Patient Management
- Low risk of morbidity from additional diagnostic testing or treatment (Examples: over-the-counter drugs, minor surgery with no identified risk

[8] *See* https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf (last accessed Mar. 10, 2022), at 15-16 (pdf page).

factors, physical therapy, occupational therapy, and IV fluids without additives[9])

58. As relevant here, the ordering and review of each unique test counts as just one item under Element 2 – Category 1.[10] And, whether the E/M Level is determined by time or MDM level, the interpretation of a diagnostic test during a patient encounter is not included in determining the E/M service, when that interpretation is reported with a separate CPT code.[11]

59. In contrast, an MDM level of "straightforward," which corresponds to a Level 2 code (CPT 99202 or 99212), requires only the following elements:[12]

(1) Element 1: Number and Complexity of Problems Addressed
- 1 self-limited or minor problem

(2) Element 2: Amount and/or Complexity of Data to be Reviewed
- Minimal or none

(3) Element 3: Risk of Complications and/or Morbidity or Mortality of Patient Management
- Minimal risk of morbidity from additional diagnostic testing or treatment (Examples: Rest, gargles, elastic bandages, superficial dressings[13])

60. CMS guidance emphasizes that a provider must "ensure that the codes selected reflect the services furnished."[14] CMS and their MACs will deny or refuse to reimburse claims billed at a higher level of E/M service than was rendered, which is commonly known in the industry as "upcoding."[15]

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[9] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf at 18 (pdf pg.) (last accessed Mar. 11, 2022).
[10] *Id*. at 3, 8-9.
[11] *Id*.
[12] *See id*. at 10-11.
[13] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf at 18 (pdf pg.) (last accessed Mar. 11, 2022).
[14] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf at 7 (pdf pg.) (last accessed Mar. 11, 2022).
[15] *See also* MLN Booklet: Medicare Fraud & Abuse, *available at* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf at 6 (pdf pg.) ("Examples of Medicare fraud include: Knowingly billing for services at a level of complexity higher than services actually provided…") (last accessed Mar. 11, 2022).

61. Further, the Claims Manual states: "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported." Claims Manual, Chapter 12, § 30.6.1(A).

62. However, because it is not feasible for MAC or CMS personnel to review every patient's medical records for the millions of claims for payment they receive from providers each year, the Medicare program relies on providers to comply with Medicare requirements and trusts providers to submit truthful and accurate certifications and claims.

63. Per the HHS Office of the Inspector General: "Payers trust you, as a [provider], to provide necessary, cost-effective and quality care…. The Government's payment of claims is generally based *solely on your representations* in the claims documents."[16]

64. The Government will "audit claims and investigate providers when it has a reason to suspect fraud," including upcoding.[17]

65. In a review of Medicare fee-for-service reimbursement data from 2020, HHS found that improper payments for office visits exceeded a billion dollars that year, of which $265 million was improperly paid out for services billed using codes 99203 and 99213.[18]

66. CMS and their MACs routinely audit providers suspected of upcoding. Novitas Solutions, the A/B MAC for New Jersey, found that the "level of care/incorrect coding" was

[16] https://oig.hhs.gov/compliance/physician-education/i-physician-relationships-with-payers/ (last accessed Mar. 11, 2022) (emphasis added).
[17] *Id.*
[18] https://www.cms.gov/files/document/2020-medicare-fee-service-supplemental-improper-payment-data.pdf (last accessed Mar. 11, 2022).

among the "most common reasons for denial" during the Targeted Probe and Educate (TPE) audits they conducted in 2018 and 2019.[19] The Department of Justice and HHS-OIG have prosecuted providers who knowingly defraud Medicare through upcoding. As one example, in September 2020, an urgent care provider in Arizona who pleaded guilty to healthcare fraud was sentenced and ordered to pay $12.5 million in restitution.[20]

67. Accordingly, a provider's false representations regarding the level of E/M service provided are material to the Government's decision to pay, and CMS and its MACs routinely deny payment on claims that they know are upcoded.

B. Defendant automatically upcoded the E/M Level of COVID test visits through the DocuTap/Experity EMR

68. Defendant uses an electronic medical records system called DocuTap, which is owned and operated by Experity, Inc. Upon information and belief, the DocuTap EMR is also called Experity (hereinafter referred to as the "EMR").

69. Relator saw the EMR in use at every Virginia clinic to which she was assigned (Roanoke, Salem, Christiansburg, Harrisonburg, Staunton, Danville, Martinsville, and Lynchburg). Upon information and belief, Defendant uses the EMR in numerous other states including West Virginia and New Jersey.

70. On March 3, 2021, Relator received an email from Jessica Aliff, an Area Medical Director for MedExpress, including certain instructions and guidelines on how to use the EMR. That email was addressed to over 50 providers, as well as the Area Medical Directors for Virginia and West Virginia.

[19] https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00222117 (last accessed Mar. 11, 2022).

[20] https://www.justice.gov/usao-az/pr/urgent-care-provider-convicted-health-care-fraud-and-ordered-pay-125-million (last accessed Mar. 11, 2022).

71. The EMR automates and streamlines certain documentation functions, including the selection of the E/M level for office visits, based on selections made by the provider in different "modules" within patients' charts. Further, the EMR will also prompt the provider to add certain information to patients' charts to maximize the E/M level.

72. When Relator selected diagnosis code Z20.828 (contact with and suspected exposure to viral communicable diseases) for all COVID testing patients pursuant to corporate policy, the EMR routinely filled in CPT codes 99203 or 99213, even for patients with no symptoms, no exposure and a negative test result. She was not able to change the CPT code or E/M level generated by the EMR.

73. Pursuant to ICD-10 guidelines, the Z20.828 code is appropriate when a patient reports exposure to someone infected with COVID-19. However, as explained below, Defendant uses the Z20.828 code as a blanket diagnosis for all COVID-19 test visits, even when a patient reports no suspected exposure to COVID-19. For someone without exposure or contact with someone actively infected with COVID-19, a screening diagnosis code (e.g., Z11.52 or Z11.59) should be used instead.

74. Upon information and belief, the vast majority of visits documented with the Z20.828 diagnosis code are automatically coded as Level 3 or higher by the EMR.

75. The CPT codes generated by the EMR for each visit are then billed to payors, including Medicare and Medicaid.

76. For example, on December 11, 2020, Patient A (No. ****0319) came to Defendant's clinic in Roanoke County, Virginia for a COVID-19 antigen test. On April 2, 2021, the patient received a billing statement for a CPT 99203 service, reflecting a diagnosis code of

Z20.828, consistent with Defendant's corporate policy. The patient's insurance was also billed separately for the COVID-19 antigen test. Patient A's insurance carrier was Aetna.

77. Medicare and Medicaid are similarly billed for the same CPT codes generated by the EMR.

C. Defendant knowingly uses the Z20.828 diagnosis code for all COVID test visits, regardless of symptoms, exposure, or necessity, resulting in upcoded claims

78. Patients at Defendant's clinics requesting a COVID-19 test are often asymptomatic, and among these, many also report no exposure to the virus and test negative for COVID-19 on the rapid test provided during the encounter.

79. The patient flow for these patients, from arrival to discharge, can be summarized as follows:

i. Patient arrives at a MedExpress clinic.
ii. Patient requests a COVID-19 test.
iii. Nasal swab specimen is taken by a medical assistant or technician, who also performs the COVID-19 antigen test at the clinic.
iv. Patient waits 15-20 minutes for the antigen test results to be ready.
v. Patient is seen by a provider, usually a nurse practitioner or physician assistant, for a short "evaluation and management" office visit.
vi. Patient is discharged.

80. For patients with neither symptoms of COVID-19 nor exposure to the virus, Defendant's providers spend just a few minutes per visit, primarily to announce the test result. Patients who test negative are sent home without follow-up care. Because these patients have no symptoms, they consequently do not engage in any discussions with the provider regarding symptoms or treatment.

81. For these patients, the service rendered by Defendant's providers does not meet the AMA guidelines requirements for a Level 3 E/M visit: the time spent per encounter does not

exceed the minimum 20 or 30-minute thresholds, and the level of medical decision making does not rise to even low complexity.

82. Specifically, Element 1 (Number and Complexity of Problems Addressed) is not satisfied because there is no "problem" addressed at the visit. There is not even a "self-limited or minor problem" (e.g., "fever, body aches, or fatigue in a minor illness,"[21] or "cold, insect bite, or tinea corporis [fungal rash]"[22]).

83. Element 2 (Amount and/or Complexity of Data to be Reviewed and Analyzed) is not met because, during these brief visits, providers do not examine prior medical records or consult other providers or independent historians. Although a COVID rapid test is ordered and the results are reviewed, the ordering and review of each "unique test" only counts as one item under Category 1: Tests and Documents, and there must be at least two items to meet that Element.

84. Element 3 (Risk of Complications and/or Morbidity or Mortality of Patient Management) is also not met because there is no additional diagnostic testing or treatment involved.

85. CMS has issued guidance on what qualifies as "low risk of morbidity from additional diagnostic testing or treatment." Among other things, "low risk" involves patient management options such as: over-the-counter drugs, minor surgery with no identified risk factors, physical therapy, occupational therapy, and IV fluids without additives.[23]

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[21] *See* https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf (last accessed Mar. 10, 2022), at 5 (pdf page).

[22] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf at 18 (pdf pg.) (last accessed Mar. 11, 2022).

[23] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf at 18 (pdf pg.) (last accessed Mar. 11, 2022).

86. Here, asymptomatic and non-exposed patients are sent home without any follow-up care after a negative COVID test. This management option for these patients is not "low risk" but rather "minimal risk," which corresponds to a Level 2 code.[24]

87. To qualify for a particular MDM level, at least two of the three elements must be satisfied. For the asymptomatic, non-exposed patients at issue, zero elements are met. Thus, these visits should have been billed at a Level 2 or not billed at all.

88. In an internal policy memo dated March 29, 2021, Defendant stated that it would not provide office visits in conjunction with COVID tests for any asymptomatic individuals covered by Defendant's Employer Health Services ("EHS") program. *See* **Exhibit A** at 5-6 (pdf pg.). This memo stated that the policy applied to all locations throughout the United States, and further the "Policy Owners and Administrators" included Defendant's VP of Clinical Operations and the Chief Medical Officer. *Id*. at 1.

89. Another internal memo titled "Asymptomatic COVID-19 Testing Costs Talking Points & FAQ" provided scripted answers to questions from patients regarding asymptomatic COVID testing. *See* **Exhibit B**. Among other things, MedExpress employees were instructed to tell patients: "If you [a patient covered under the EHS program] are not showing any symptoms, you are not required to be examined by a provider before receiving the COVID-19 test." However, "if you are symptomatic, you will need to be examined by a provider prior to any testing." *Id*.

90. MedExpress bills employers a flat $195 fee per COVID-19 screening test under the EHS program. *Id*.

91. Most patients who receive COVID screenings under the EHS program also report no symptoms or exposure to COVID-19.

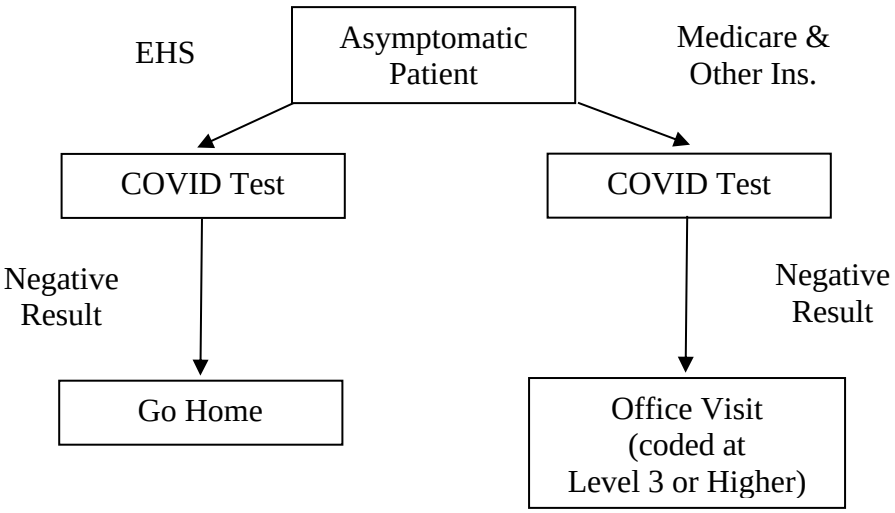
[24] *See id*. (listing "Rest" under management options with minimal level of risk).

92. As such, most EHS patients are, in relevant respects, *indistinguishable* from the asymptomatic, non-exposed patients for whom office visits are billed to insurance payors, including Medicare and Medicaid.

93. But, unlike the patients with insurance payors, asymptomatic EHS patients do not receive any office visit at MedExpress. After the COVID test is administered by a medical assistant or technician (steps (i) through (iv) in paragraph 79 *supra*), the patient is sent home or back to work with a negative result without having to meet with a provider.

94. This contrast in the services provided, based on who is paying, illustrates Defendant's awareness that an office visit for routine COVID screening tests for asymptomatic individuals cannot be justified as medically necessary, and that the office visits for non-EHS patients are rendered for the sole purpose of obtaining insurance money.

95. The following flowchart illustrates Defendant's profit-seeking double standards.



96. Defendant dispenses with the unnecessary office visits for EHS patients because it can do so without affecting revenue, since it receives a flat fee for these patients.

97. Thus, Defendant knows that billing for the visits provided to non-EHS patients, even at Level 2, is fraudulent. But Defendant does not stop there: to eke out every last penny of

government insurance funds, Defendant upcodes these visits to Medicare and Medicaid as E/M Level 3 or higher level visits.

98. Defendant maintained a corporate policy of always using the Z20.828 diagnosis code for all COVID-test visits, even when this diagnosis was fraudulent for patients without symptoms or exposure. As explained *supra*, the Z20.828 code automatically produced at least a Level 3 E/M code within the EMR for the vast majority of asymptomatic, non-exposed patients, which was then billed to payors including Medicare and Medicaid.

99. Relator attended monthly provider meetings, attended by all providers in the Virginia and West Virginia areas, along with Defendant's Area Medical Directors Dr. Jessica Aliff and Dr. Timothy Mynes, and Regional Medical Director Dr. Ranjit Singh. During these monthly calls, Dr. Aliff and Dr. Mynes told providers to always use the Z20.828 code for any visits related to COVID-19, including COVID-19 test visits.

100. Relator received corporate policy emails from area and regional medical directors, similar to the emails in paragraph 70 *supra*, mandating that providers use the Z20.828 code for COVID-related visits.

101. Relator was repeatedly given the same instruction by the Center Manager of each clinic where she worked.

102. Further, at every clinic where Relator worked, she found written instructions next to computer stations instructing providers to use the Z20.828 code for COVID-19 test visits.

103. Defendant also made it clear to Relator that her coding/billing practices were being closely reviewed. At her six-month performance review in or around October 2020, lead Physician Assistant Kristin Youther produced Relator's billing statistics and coding data specific to the patients Relator had seen. Youther showed Relator the percentage of each E/M level Relator had

coded and suggested ways that Relator could improve her billing. At this meeting, Relator also reported to Youther that she could not lower or otherwise modify the E/M code generated by the EMR.

104. Defendant is aware that the use of the Z20.828 diagnosis code, pursuant to its corporate policy, results in a Level 3 E/M code in the EMR. Defendant is also aware that, for the subset of asymptomatic patients described *supra*, a Level 3 code does not reflect the service and medical decision-making provided.

105. Relator has reviewed patient charts in the EMR and has confirmed that encounters for patients with no symptoms, no exposure, and a negative COVID-19 test result, were coded and billed to Medicare and Medicaid as Level 3 E/M visits. Specifically, on March 20-21, 2021, Relator was assigned to the Salem, Virginia clinic. That weekend, Relator reviewed her documentation which showed that visits with Medicare beneficiaries had been fraudulently upcoded to Level 3, even though the beneficiaries had no symptoms, no exposure, and a negative COVID test.

106. Defendant has presented reimbursement claims to CMS, New Jersey DMAHS and Virginia DMAS for the treatment of Medicare and Medicaid beneficiaries. These claims contain the upcoding described *supra*.

COUNT I
FEDERAL FALSE CLAIMS ACT:
PRESENTATION OF FALSE CLAIMS

107. As described *supra*, Defendant knowingly presented or caused the presentation of claims for payment to CMS and/or its MACs for services that were medically unnecessary and not rendered at the level for which reimbursement was claimed.

108. The presentation of these false claims caused CMS and/or its MACs to pay out monies that they would not have paid if they had known of the falsity of these claims.

109. CMS and its MACs are grantees or other recipients of money from the United States Government within the meaning of 31 U.S.C. § 3729(b)(2)(A)(ii). All such money is to be spent to advance the United States' interest in the Medicare program.

110. Accordingly, Defendant's knowing presentations of false or fraudulent claims for payment to CMS and/or its MACs were violations of 31 U.S.C. § 3729(a)(l)(A).

111. Each presentation of a false or fraudulent claim to CMS and/or its MACs is a separate violation of the FCA.

112. By reason of the false or fraudulent claims that Defendant knowingly presented, the United States has been damaged in an amount to be proven at trial.

COUNT II
FEDERAL FALSE CLAIMS ACT:
FALSE RECORD OR STATEMENT

113. As described *supra*, Defendant knowingly made and used false records and statements when they caused claims for payment to be presented to CMS and/or its MACs, including false documentation of patient visit records.

114. The making and use of these false records or statements caused CMS and/or its MACs to pay out monies that they would not have paid if they had known of the falsity of Defendant's records and statements.

115. CMS and its MACs are grantees or other recipients of money from the United States Government within the meaning of 31 U.S.C. § 3729(b)(2)(A)(ii). All such money is to be spent to advance the United States' interest in the Medicare program.

116. Accordingly, Defendant's knowing making and use of false records or statements material to the false or fraudulent claims for payment that Defendant submitted to CMS and/or its MACs were violations of 31 U.S.C. § 3729(a)(l)(B).

117. Each such making or use of a false record or statement is a separate violation of the FCA.

COUNT III
VIRGINIA FRAUD AGAINST TAXPAYERS ACT:
PRESENTATION OF FALSE CLAIMS

118. As described *supra*, Defendant knowingly presented or caused the presentation of claims for payment to the Commonwealth of Virginia and DMAS for services that were medically unnecessary and not rendered at the level for which reimbursement was claimed.

119. The presentation of these false claims caused the Commonwealth to pay out monies under the Virginia Medicaid program that they would not have paid if they had known of the falsity of these claims.

120. Accordingly, Defendant knowingly presented false or fraudulent claims for payment in violation of Va. Code Ann. § 8.01-216.3(A)(1).

121. Each false or fraudulent claim submitted to the Virginia Medicaid program is a separate violation of the Virginia Fraud Against Taxpayers Act.

122. By reason of the false or fraudulent claims that Defendant knowingly presented, the Commonwealth of Virginia has been damaged in an amount to be proven at trial.

COUNT IV
VIRGINIA FRAUD AGAINST TAXPAYERS ACT:
FALSE RECORD OR STATEMENT

123. As described *supra*, Defendant knowingly made and used false records and statements when they caused claims for payment to be presented to Virginia and DMAS, including false documentation of patient visit records.

124. Accordingly, Defendant's knowing making and use of false records or statements material to the false or fraudulent claims for payment that Defendant submitted to Virginia and DMAS were violations of Va. Code Ann. § 8.01-216.3(A)(2).

125. Each making or using of false records or statements is a separate violation of the Virginia Fraud Against Taxpayers Act.

COUNT V
NEW JERSEY FALSE CLAIMS ACT:
PRESENTATION OF FALSE CLAIMS

126. As described *supra*, Defendant knowingly presented or caused the presentation of claims for payment to the State of New Jersey and DMAHS for services that were medically unnecessary and not rendered at the level for which reimbursement was claimed.

127. The presentation of these false claims caused the State to pay out monies under the New Jersey Medicaid program that they would not have paid if they had known of the falsity of these claims.

128. Accordingly, Defendant knowingly presented false or fraudulent claims for payment in violation of N.J. Stat. Ann. § 2A:32C-3(a).

129. Each false or fraudulent claim submitted to the New Jersey Medicaid program is a separate violation of the New Jersey False Claims Act.

130. By reason of the false or fraudulent claims that Defendant knowingly presented, the State of New Jersey has been damaged in an amount to be proven at trial.

COUNT VI
NEW JERSEY FALSE CLAIMS ACT:
FALSE RECORD OR STATEMENT

131. As described *supra*, Defendant knowingly made and used false records and statements when they caused claims for payment to be presented to New Jersey and DMAHS, including false documentation of patient visit records.

132. Accordingly, Defendant's knowing making and use of false records or statements material to the false or fraudulent claims for payment that Defendant submitted to New Jersey and DMAHS were violations of N.J. Stat. Ann. § 2A:32C-3(b).

133. Each making or using of false records or statements is a separate violation of the New Jersey False Claims Act.

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PRAYER FOR RELIEF

WHEREFORE, Relator respectfully requests that this Court enter judgment in her favor and that of the United States, the Commonwealth of Virginia, and the State of New Jersey and against Defendant, granting the following on all Counts:

(A) an order requiring Defendant to immediately cease and desist from the conduct described herein and all similar conduct;

(B) an award to the United States for treble its damages, a statutory penalty for each violation of the FCA, and for its costs pursuant to 31 U.S.C. § 3729(a)(3);

(C) an award to Virginia for treble its damages, a statutory penalty for each violation of the Virginia Fraud Against Taxpayers Act, and for its costs pursuant to Va. Code Ann. § 8.01-216.3(A);

(D) an award to New Jersey for treble its damages, a statutory penalty for each violation of the New Jersey False Claims Act, and for its costs pursuant to N.J. Stat. Ann. § 2A:32C-8;

(E) an award to Relator in the maximum amount permitted under 31 U.S.C. § 3730(d), Va. Code Ann. § 8.01-216.7, and N.J. Stat. Ann. § 2A:32C-7, and for the reasonable attorney's fees and costs she incurred in prosecuting this action;

(F) awards to the United States, the Commonwealth of Virginia, the State of New Jersey, and Relator for pre- and post-judgment interest at the rates permitted by law; and

(G) an award of such other and further relief as this Court may deem to be just and proper.

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DEMAND FOR TRIAL BY JURY

Pursuant to Rule 38(b) of the Federal Rules of Civil Procedure, Relator demands trial by jury on all questions of fact raised by this First Amended Complaint.

Dated: March 21, 2022

Respectfully submitted,

BROWN, LLC

/s/ Jason T. Brown
Jason T. Brown (NJ Bar # 35921996)
111 Town Square Place, Suite 400
Jersey City, NJ 07310
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(855) 582-5297 (fax)
jtb@jtblawgroup.com

CERTIFICATE OF SERVICE

I hereby certify that on March 21, 2022, I caused a copy of the foregoing First Amended Complaint to be filed with the Clerk of the Court through the CM/ECF system, which will send notification of such filing to all counsel of record, constituting service in accordance with Federal Rule of Civil Procedure 5(b) and Local Rule 5.2.

/s/ Jason T. Brown
Jason T. Brown
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EXHIBIT A

MedExpress Policy Summary
For Internal Use Only

MedExpress

Policy Information			
Policy Title	Current List of Standing Orders Policy	**Current Version Publish Date**	3/29/2021
Updated by Committee	04/2014, 12/2014, 05/2016, 03/2018, 06/2018, 08/2018, 09/2018, 02/2019, 03/2019, 08/2019, 10/2019, 9/2020, 11/2020, 03/2021	**Original Effective Date**	08/2013
Policy Identifier		**Reviewed by Committee**	3/2021
Policy Applicability			
Country	United States	**State/Territory**	All MedExpress States/Territories
Employee Applicability	All MedExpress Employees	**UHG Business Applicability**	
Contractor Applicability	Specific to contractors of MedExpress	**Market Group**	MedExpress
External Segment	MedExpress Corporate	**Internal Segment**	MedExpress Corporate
Business		**Division**	
Products Impacted			
Exception Description			

Policy Statement and Purpose[1]

To provide a recorded current list of standing orders as referenced in the Standing Order Policy.

Policy Definitions

[1] The information set forth herein constitute recommendations relating to clinical care; nevertheless, the independent medical judgment of the treating clinician prevails and controls.

Policy Provisions

I. **Standing Order: Flu Vaccine**

A. *Indication(s):*

a. For patients requesting influenza vaccination

B. *Contraindication(s):*

a. Prior sensitivity or allergy to any component of the influenza vaccine being given. Influenza immunization requires completion of a questionnaire by the patient; depending upon the formulation being used, allergy to eggs, feathers, chicken, latex or certain preservatives may be a contraindication, as is a history of Guillain-Barre' Syndrome.

b. Younger than established age parameters for pediatric patients

II. **Standing Order: Rapid Strep Test**

A. *Indication(s):*

a. Patients who present with a chief complaint of an isolated sore throat and do not complain of cough, runny nose, and/or congestion.

B. *Contraindication(s):*

a. None.

III. **Standing Order: Macroscopic Urinalysis, Clean Catch Specimen**

A. *Indication(s):*

a. Female patients with a complaint of urinary frequency or urgency, pain or pressure with urination, or blood in the urine.

b. Female patients with a complaint of abdominal pain.

c. All patients presenting with a complaint of nausea, vomiting, or diarrhea.

B. *Contraindication(s):*

a. None.

IV. **Standing Order: Urine Pregnancy Test**

A. *Indication(s):*

a. Female patients of child bearing age (10-60) with a complaint of abdominal pain.

b. Female patients who are of child bearing age who are receiving X-ray studies **and** believe the possibility of being pregnant exists.

B. *Contraindication(s):*

a. None.

V. **Standing Order: Extremity X-ray Studies**

A. *Indication(s):*

a. Patients with well-localized pain in an extremity who sustained a traumatic injury within the past 72 hours.

B. *Contraindication(s):*

a. Pregnancy.

b. In an IAP lead center, the IAP must first evaluate the patient and then place the order(s) for the x-ray studies.

VI. **Standing Order: X-ray studies ordered by Independent Advanced Practice Clinician**

A. *Indication(s):*

a. RT's and LMRT's may perform x-ray orders as determined medically necessary by the Independent

Advanced Practice Clinician.

B. *Contraindication(s):*
   a. Patients who have not been evaluated by the Independent Advanced Practice Clinician.

VII. Standing Order: Acetaminophen/Ibuprofen

A. *Indication(s):*
   a. Pediatric patients with a fever over 101 degrees F (See dosing chart).
   b. All adult patients with a fever over 101 degrees F (dose: 650mg of Acetaminophen – unless self-dosed at home).

B. *Contraindication(s):*
   a. Patients with sensitivities/allergies to the medication.
   b. Pediatric patients who have received a dose of the same medication within the past 6 hours.
   c. Adult patients who have received Acetaminophen within the past 4 hours.

VIII. Standing Order: TB Testing

A. *Indication(s):*
   a. For patients requesting testing as part of an established Employer Health Services Profile, for employment, or for school entrance requirements. All MedExpress Policies & Procedures regarding TB testing shall be followed.

B. *Contraindication(s):*
   a. Prior reaction, sensitivity, or allergy.

IX. Standing Order: Immunizations

A. *Indication(s):*
   a. For patients requesting immunization as part of an established Employer Health Services Profile, for employment, and for school entrance requirements, and to update Tetanus (Td/Tdap) for visits associated with a wound injury. Patients receiving tetanus prophylaxis for a wound injury must be evaluated by the provider prior to being discharged.

B. *Contraindication(s):*
   a. Prior sensitivity or allergy to any component of the immunization being given. Influenza immunization requires completion of a questionnaire by the patient and, depending upon the formulation being used, allergy to eggs, feathers, chicken, latex or certain preservatives may be a contraindication, as is a history of Guillain-Barre' Syndrome.

X. Standing Order: Titers

A. *Indication(s):*
   a. For patients requesting titers as part of an established Employer Health Services profile, for employment, and for school entrance requirements.

B. *Contraindication(s):*
   a. None.

XI. Standing Order: Visual Acuity

A. *Indication(s):*
   a. Patients with an eye complaint.

B. *Contraindication(s):*
   a. None.

XII. Standing Order: Electrocardiogram (EKG or ECG)

A. Indication(s):

a. Patients with complaint of chest pain that is believed to potentially be of cardiac origin. A provider shall immediately be notified if an EKG is performedon a patient as a standing order.

B. Contraindication(s):

a. None.

XIII. Standing Order: Oxygen Therapy (O_2)

A. Indication(s):

a. Patients with complaint of chest pain that is believed to potentially be of cardiac origin, patients who present in obvious respiratory distress, or **patients with an oxygen saturation reading of 92%* or less. (*Parameter in CO is patients with an oxygen saturation reading of 87% or less)**. A provider shall immediately be notified if a patient is placed on oxygen therapy as a standing order.

B. Contraindication(s):

a. Patients who are not complaining of chest pain and are in no respiratory distress, are not tachypneic (breathing rapidly), and who report that the oxygen saturation reading obtained is baseline for them due to underlying chronic medical problems. **A provider shall immediately be notified if a patient has an oxygen saturation reading of 92%* or less (*Parameters in CO is patients with an oxygen saturation reading of 87% or less)**, even if they are not placed on oxygen due to this contraindication.

XIV. Standing Order: Peak Flows

A. Indication(s):

a. Patients receiving respiratory treatment(s) shall perform pre and post treatment peakflows.

B. Contraindication(s):

a. Emergency situations.

b. Patients unable to follow instructions to perform test correctly (i.e. young pediatric patients, mentally impaired etc.).

XV. Standing Order: Repeat Critical Vital Signs

A. Indication(s):

a. Patients found to have critical vital signs during clinical intake or any part of their visit shall have vital signs repeated and documented. A provider shall be notified immediately of critical vitalsigns.

B. Contraindication(s):

a. None.

XVI. Standing Order: Throat culture

A. Indication(s):

a. Obtain a second throat swab to be sent for a culture on patients younger than 18 with a negative rapid strep result.

B. Contraindication(s):

a. None.

XVII. Standing Order: Lab Testing

A. *Indication(s):*
   a. For patients requesting testing as part of an established Employer Health Services/Wellness Profile. Follow all MedExpress Policies & Procedures regarding lab testing.
B. *Contraindication(s):*
   a. None.

XVIII. **Standing Order: Post IV or PO Hydration Urinalysis and Vital Signs**
A. *Indication(s):*
   a. All patients who have received IV or PO fluids for hydration; obtain a urine specimen for urinalysis to assess the patient's hydration status and ability to void prior to discharge.
   b. All patients who have received IV or PO fluids for hydration; obtain vital signs post hydration prior to discharge. Vital signs to include: B/P; pulse; respirations; temperature and oxygen saturation.
B. *Contraindications:*
   a. None.

XIX. Standing Orders : Solutions for Reconstitution and Dilution
A. Indication(s):
   a. IM reconstitution of Ceftriaxone (Rocephin):
      1. Lidocaine 1% is the preferred diluent for intramuscular injections.(See Medication Administration Guidelines for dilution instructions and manufacturer's insert)
      2. NS for injection can be used if Lidocaine is contraindicated.
   b. IM reconstitution Ampicillin/Sulbactam (Uynasyn):
      1. Lidocaine 1% is the preferred diluent for intramuscular injections.(See *Medication Administration Guidelines* for dilution instructions and manufacturer's insert)
      2. Sterile water for injection can be used if Lidocaine is contraindicated.
   c. 100 CC NS mini-bag diluent (piggyback) for infusion.
   d. NS for injection diluent for IV push dilution.
B. Contraindication(s):
      1. Patients with allergies or sensitivity.

XX. **Standing Order: High Glucose Reading Repeat and Urinalysis**
A. *Indication(s):*
   a. Patient found to have a glucose reading of >444; repeat the glucose test and obtain a urine specimen for urinalysis
   b. Notify a provider immediately of the glucose and urine results.
B. *Contraindication(s):*
   a. None.

XXI. **Standing Order: Employer Health Services: Asymptomatic COVID PCR testing**
A. *Indication for implementation of this standing order:*
   • Patient presents for COVID testing at the direction of their employer who is paying at the time of

service or has an EHS profile and is preapproved for direct billing.
- Patient is screened by clinical staff for COVID symptoms and is determined to be **asymptomatic**.
- If the criteria above are met; COVID swab may be collected and processed following MedExpress policies and protocols *without a provider examination.*

B. *Contraindication for implementation of this standing order:*
- The patient has any COVID symptoms as defined on the EHS Asymptomatic COVID Screening form.
- Employer does not have an established EHS profile or has not made arrangements for payment at time of service.

XXII. Standing Order for Flu Rapid Test for Symptomatic Urgent Care Patients

A. *Indication(s):*
   a. Clinical staff to collect a rapid flu test prior to the urgent care patient being seen by a provider when a patient presents with the following symptoms for ≤ 72 hours: fever, cough, shortness of breath, fatigue, sore throat, runny/stuffy nose, muscle aches and/or headache.

B. *Contraindication(s):*
   a. Patient's symptoms are greater than 72 hours.

XXIII. Standing Order for COVID Rapid Test for Symptomatic Urgent Care Patients

A. *Indication(s):*
   a. Clinical staff to collect a rapid COVID test prior to the urgent care patient being seen by a provider when a patient presents with the following symptoms for <7days: fever, cough, shortness of breath, fatigue, sore throat, runny/stuffy nose, muscle aches, headache and/or loss of taste or smell.

B. *Contraindication(s):*
   a. Asymptomatic urgent care patients (follow standing order XXIV for COVID Rapid Test for Asymptomatic Urgent Care Patients).
   b. Asymptomatic EHS patient (follow standing order XXI for PCR testing for EHS patients)
   c. Patient's symptoms are greater than 7 days

XXIV. Standing Order for COVID Rapid Test for Asymptomatic Urgent Care Patients

A. *Indication(s):*
   a. Any asymptomatic urgent care patient registered to be seen by the provider who is requesting rapid COVID testing,

B. *Contraindication(s):*
   a. Asymptomatic EHS patient (follow standing order XXI for PCR testing for EHS patients)

Policy Contacts			
Policy Resources Available		Contact(s)	
Email Questions		Telephone	
Resources and Materials for this Policy			
Related Policies	• Clinical Intake (Triage) Process and Guidelines Policy • Standing Orders Policy		
Related Procedures			
Related Internal or External Links			
Related Process Instructions / References			
Relevant Legal or Regulatory Guidance / Requirements			
Related Job Aids			
Related Process Maps			
Other Reference Links			
Attachments			
Business and Regulatory Requirements			
Description of Business / Regulatory Requirements			
Related Documents			
Policy Owners and Administrators			
Policy Administrator	VP Clinical Operations	Executive Owner	Chief Medical Officer
Policy Owner	VP Clinical Operations		
Review Frequency	Annually	Next Required Review Date	07/2022
Training and Communication			
Training Owner / Group		Communications Owner / Group	
Training Required?	No	Formal Communications Required?	Yes

Required Training Frequency		**Communication Channel**	Connect ME
How is Training Delivered?			

EXHIBIT B

MedExpress

ASYMPTOMATIC COVID-19 TESTING COSTS TALKING POINTS & FAQs

NOT FOR DISTRIBUTION

The purpose of these talking points is to provide support to center teams who are answering questions from patients regarding costs associated with asymptomatic COVID-19 evaluations and testing. Please note that these responses are not for distribution and should only be used when asked directly about the topics below. If you receive additional questions not listed here related to this topic, please reach out to centerops@medexpress.com for additional information.

Frequently Asked Questions for COVID-19 Testing for Employers:
These responses are intended to assist with questions from employers or their employees when they present to the center seeking a COVID-19 test in order to return to work.

1. **I'm an individual requesting a return-to-work COVID-19 test, and I'd like to have my employer receive the bill. Can I?**
    - If your employer has established a COVID-19 return-to-work payment program with us, they will be billed directly for your asymptomatic COVID-19 test today. If we do not have a COVID-19 testing payment program established with your employer, we will need to contact them to collect payment at the time of service. Do you have a contact that you think would be best to reach out to?
2. **If my employer is paying for this service, how much does it cost?**
    - The cost for an employer-related asymptomatic COVID-19 test is $195.
3. **Since my employer is requiring a COVID-19 test for me to return to work, but I don't feel ill, will I need to see a provider today?**
    - If you are not showing any symptoms, you are not required to be examined by a provider before receiving the COVID-19 test.
4. **If I'm not feeling well or have symptoms during the test, what happens next?**
    - To ensure you are receiving the proper care, if you are symptomatic, you will need to be examined by a provider prior to any testing.
    - Please note, this will no longer be considered an asymptomatic test and you will be charged for an urgent care visit and any additional services that are provided.

Frequently Asked Questions for COVID-19 Testing for Individuals
These responses are intended to assist with questions from individuals that are not associated with an employer or who are paying for their visit via Prompt-Pay or their insurance.

5. **Why do I have to pay a copay?**
    - When you visit MedExpress for an asymptomatic COVID-19 evaluation and test, you will receive our full package of services, including a complete examination by one of our licensed medical providers, a COVID-19 test. The COVID-19 evaluation and testing will be billed through your insurance, and as such, your visit is subject to deductibles and any copays you may have as part of your insurance plan.

MedExpress

ASYMPTOMATIC COVID-19 TESTING COSTS
TALKING POINTS & FAQs

6. **Why is the cost of asymptomatic COVID-19 testing at MedExpress so high when other health care organizations in the community are doing it for free?**
    - Our asymptomatic testing program was designed for use by employers who are helping their employees return to work safely.
    - Individuals who choose to receive asymptomatic COVID-19 testing at MedExpress will receive the full package of services, including a complete examination by one of our licensed medical providers and a COVID-19 test.
    - If you visit us for asymptomatic testing and are not associated with one of our employer clients, the COVID-19 evaluation and testing will be billed through your insurance, and as such, your visit is subject to deductibles and any co-pays you may have as part of your insurance plan. Many health insurance companies across the country have stated that they will cover costs associated with medical care for COVID-19 related visits. However, it is always a good idea to check with your insurance company first to learn what is covered.
    - If your testing is not associated with an employer request, the total estimated cost for today is approximately $150 dollars, although this cost is dependent on the specifics of your insurance plan. This price does not include any associated lab costs for processing your COVID-19 test sample. Please know that our lab partners will bill you separately for their service.
7. **Will I need to see a provider today?**
    - Yes, all individuals presenting for an asymptomatic COVID-19 test who are not associated with an employer will receive a full examination by one of our medical providers prior to receiving a COVID-19 test.
8. **Why isn't MedExpress taking advantage of CARES Act funding that would make COVID-19 testing free?**
    - MedExpress did not apply for funding from the CARES Act in an effort to ensure that other smaller health care organizations and private doctors' offices receive the needed funds to continue to provide important health care services throughout the COVID-19 pandemic. Therefore, our services are not covered under the CARES Act.
    - To find a list of other community-based COVID-19 testing sites, visit: https://www.hhs.gov/coronavirus/community-based-testing-sites/index.html