SUMMONS - CIVIL

JD-CV-1 Rev. 4-16
C.G.S. §§ 51-346, 51-347, 51-349, 51-350, 52-45a, 52-48, 52-259, P.B. §§ 3-1 through 3-21, 8-1, 10-13

STATE OF CONNECTICUT
SUPERIOR COURT
www.jud.ct.gov

See other side for instructions

☐ "X" if amount, legal interest or property in demand, not including interest and costs is less than $2,500.
☐ "X" if amount, legal interest or property in demand, not including interest and costs is $2,500 or more.
☒ "X" if claiming other relief in addition to or in lieu of money or damages.

TO: Any proper officer; BY AUTHORITY OF THE STATE OF CONNECTICUT, you are hereby commanded to make due and legal service of this Summons and attached Complaint.

Address of court clerk where writ and other papers shall be filed *(Number, street, town and zip code) (C.G.S. §§ 51-346, 51-350)*	Telephone number of clerk *(with area code)*	Return Date *(Must be a Tuesday)*
95 Washington St., Hartford, CT 06106	(860) 548-2700	August 22, 2017 (Month, Day, Year)
☒ Judicial District ☐ Housing Session ☐ G.A. Number:	At *(Town in which writ is returnable) (C.G.S. §§ 51-346, 51-349)* Hartford	Case type code *(See list on page 2)* Major: M Minor: 90

For the Plaintiff(s) please enter the appearance of:

Name and address of attorney, law firm or plaintiff if self-represented *(Number, street, town and zip code)*	Juris number *(to be entered by attorney only)*
AAG Richard M. Porter, Office of the Attorney General, 55 Elm St., P.O. Box 120, Hartford, 06141	423015

Telephone number *(with area code)*	Signature of Plaintiff *(If self-represented)*
(860) 808-5040	

The attorney or law firm appearing for the plaintiff, or the plaintiff if self-represented, agrees to accept papers (service) electronically in this case under Section 10-13 of the Connecticut Practice Book. ☒ Yes ☐ No

Email address for delivery of papers under Section 10-13 *(if agreed to)*: rick.porter@ct.gov

Number of Plaintiffs: 1 | Number of Defendants: 2 | ☐ Form JD-CV-2 attached for additional parties

Parties	Name *(Last, First, Middle Initial)* and Address of Each party *(Number; Street; P.O. Box; Town; State; Zip; Country, if not USA)*	
First Plaintiff	Name: State of Connecticut c/o Office of the Attorney General Address: 55 Elm Street, P.O. Box 120, Hartford, CT 06141-0120	P-01
Additional Plaintiff	Name: Address:	P-02
First Defendant	Name: Ramil Mansourov Address: 119 Tokeneke Road, Darien, CT 06820	D-01
Additional Defendant	Name: Ramil Mansourov, LLC Address: c/o Agent for Service: Ramil Mansourov, 119 Tokeneke Road, Darien, CT 06820	D-02
Additional Defendant	Name: Address:	D-03
Additional Defendant	Name: Address:	D-04

Notice to Each Defendant

1. **YOU ARE BEING SUED.** This paper is a Summons in a lawsuit. The complaint attached to these papers states the claims that each plaintiff is making against you in this lawsuit.
2. To be notified of further proceedings, you or your attorney must file a form called an "Appearance" with the clerk of the above-named Court at the above Court address on or before the second day after the above Return Date. The Return Date is not a hearing date. You do not have to come to court on the Return Date unless you receive a separate notice telling you to come to court.
3. If you or your attorney do not file a written "Appearance" form on time, a judgment may be entered against you by default. The "Appearance" form may be obtained at the Court address above or at *www.jud.ct.gov* under "Court Forms."
4. If you believe that you have insurance that may cover the claim that is being made against you in this lawsuit, you should immediately contact your insurance representative. Other action you may have to take is described in the Connecticut Practice Book which may be found in a superior court law library or on-line at *www.jud.ct.gov* under "Court Rules."
5. If you have questions about the Summons and Complaint, you should talk to an attorney quickly. **The Clerk of Court is not allowed to give advice on legal questions.**

Signed *(Sign and "X" proper box)*		Name of Person Signing at Left	Date signed
[signature]	☒ Commissioner of the Superior Court ☐ Assistant Clerk	Richard M. Porter	07/10/2017

If this Summons is signed by a Clerk:
a. The signing has been done so that the Plaintiff(s) will not be denied access to the courts.
b. It is the responsibility of the Plaintiff(s) to see that service is made in the manner provided by law.
c. The Clerk is not permitted to give any legal advice in connection with any lawsuit.
d. The Clerk signing this Summons at the request of the Plaintiff(s) is not responsible in any way for any errors or omissions in the Summons, any allegations contained in the Complaint, or the service of the Summons or Complaint.

For Court Use Only
File Date

I certify I have read and understand the above:	Signed *(Self-Represented Plaintiff)*	Date	Docket Number

RETURN DATE: AUGUST 22, 2017

STATE OF CONNECTICUT, *Plaintiff*	:	SUPERIOR COURT
	:	
v.	:	JUDICIAL DISTRICT OF HARTFORD
	:	
RAMIL MANSOUROV AND RAMIL MANSOUROV, LLC *Defendants*	:	JULY 10, 2017

COMPLAINT

Plaintiff, the State of Connecticut, represented by George Jepsen, Attorney General for the State of Connecticut, alleges the following against Ramil Mansourov (Defendant Mansourov) and Ramil Mansourov, LLC (Defendant Mansourov LLC) (Defendant Mansourov and Defendant Mansourov LLC collectively referred to as Defendants).

SUMMARY

The State of Connecticut brings this complaint under the Connecticut False Claims Act, Conn. Gen. Stat. §§ 4-274 — 4-289 (the Act), alleging that during the period beginning in November 2013 and continuing through at least October 2016, Defendant Mansourov engaged in a pervasive and illegal scheme to bill the Connecticut Medicaid program and collect millions of dollars for services he never provided to his Medicaid patients. This complaint alleges that Defendant Mansourov, using the Defendant Mansourov LLC which he controlled, knowingly created and submitted false claims for reimbursement for medical services which he never provided to indigent and/or disabled Connecticut residents who receive health care through Connecticut's Medicaid program. This complaint further alleges that the Defendants knowingly fabricated medical records and provided the false records to state auditors in order to conceal and avoid repaying the fraudulently obtained payments. The State of Connecticut seeks treble damages, civil penalties, and other relief for Defendants' illegal conduct.

PARTIES

1. The plaintiff is the State of Connecticut, represented by George Jepsen, Attorney General. 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.

2. Defendant Mansourov is a physician licensed by the State of Connecticut and a resident of Darien, Connecticut. During the relevant time period for the events described in this Complaint Defendant Mansourov transacted business in the State of Connecticut.

3. Defendant Mansourov LLC, Ramil Mansourov, LLC, is a limited liability company formed by Defendant Mansourov. On information and belief, the Defendant Mansourov is the sole equity holder of Defendant Mansourov LLC.

4. The relevant time period for the causes of action set forth below is November 2013 through at least October 2016.

LEGAL AND PUBLIC POLICY BACKGROUND

5. The Act provides in relevant part, with respect to claims for payment made to a state-administered health program, that any person who: (1) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (2) knowingly makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim; (3) knowingly makes, uses or causes to be made or used, a false record material to an obligation to pay money; or (4) knowingly conceals or knowingly and improperly avoids an obligation to pay money, is liable to the State of Connecticut for relief, including civil penalties and treble damages. Conn. Gen. Stat. §§ 4-275 (a)(1), (a)(2), (a)(7), and (a)(8); Conn. Gen. Stat. §4-275 (b).

6. The Act also provides that an "obligation" includes the retention of an overpayment of state monies. Conn. Gen. Stat. § 4-274(5). An obligation to pay money to a state-administered health program includes the obligation to repay the state an overpayment retained by a healthcare provider. Conn. Gen. Stat. § 4-274(5) and Conn. Gen. Stat. §§ 4-275(a)(7) and (8).

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. 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.

9. The State of Connecticut, through the Department of Social Services (DSS or the Department), administers the Connecticut Medical Assistance Program (CMAP). CMAP includes the State of Connecticut's Medicaid program. CMAP, including Medicaid, is a state-administered health or human services program. Conn. Gen. Stat. § 4-274(7). CMAP pays enrolled healthcare providers for health care benefits provided to program recipients.

10. The DSS Commissioner is authorized to promulgate regulations as are necessary to administer 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. CMAP requires all providers to enroll and enter into an agreement with the Department, known as a provider agreement. This agreement, which is periodically updated, remains in effect for the duration specified in the agreement. The provider agreement specifies conditions and terms that govern the program which the provider is mandated to adhere to in order to participate in the program. R.C.S.A. §§ 17b-262-339; 17b-262-524.

12. Providers enroll in CMAP as performing provers and/or billing providers. For physicians, the physician who actually performs the service must enroll as a performing provider. The physician, physician group, or other entity that submits the claim to CMAP must also enroll as a billing provider. R.C.S.A. §§ 17b-262-338(6) and (42), and R.C.S.A. §§ 17b-262-339(b) and(c).

13. During the relevant time period Defendant Mansourov was enrolled in CMAP as a billing provider and performing provider, and was a party to a provider agreement with the Department.

14. During the relevant time period Defendant Mansourov LLC was enrolled in Medicaid as a billing provider, and was a party to a provider agreement with the Department. On or about November 1, 2013, Defendant Mansourov ceased billing Medicaid as the billing provider for services he purportedly performed. Thereafter he used and caused Defendant Mansourov LLC to bill Medicaid for services he purportedly performed as the performing provider.

15. The provider agreements between the Defendants and the Department (Provider Agreements) obligate the Defendants to submit to the Department only those claims which are for medically necessary goods and services which were actually provided to the person in whose name the claim is made. Provider Agreements, Para. 14(b). *See, e.g,*. copy attached as Exhibit A.

CMAP PAYMENT REQUIREMENTS

16. To receive payment for goods and services provided to CMAP beneficiaries, providers are required among other things to meet and maintain all DSS enrollment requirements including the timely submission of a complete provider enrollment or reenrollment form and submission of all enrollment information and such affidavits as the DSS may require. R.C.S.A. §§ 17b-262-339 and 17b-262-524.

17. Compliance with all laws, regulations, and DSS enrollment requirements is an express condition of payment for providing services under the Medicaid program. Regulations of Connecticut State Agencies §§ 17b-262-522, 17b-262- 524, and 17b-262-526.

18. Payment is available to billing providers for medically necessary services provided by the performing physician to the Medicaid beneficiary in whose name the claim is made, provided that the services are within the performing provider's scope of practice, and the provider documents the services in the client's medical record. R.C.S.A. §§ 17b-262-341(2) and 343.

19. State regulations and the Defendants' Provider Agreements require that any payment, or part thereof, for CMAP goods or services which represents an excess over the payment authorized, or any payment owed to DSS because of a violation due to abuse or fraud, shall be payable to the Department. R.C.S.A. § 17b-262-533; Provider Agreements, Para. 23. The regulations define "overpayment" to mean "any payment that represents an excess over the allowable payment under state law including, but not limited to, amounts obtained through fraud and abuse." R.C.S.A. § 17b-262-523(18).

20. Section 6402(a) of the Patient Protection and Affordable Care Act of 2010 (Enhanced Medicare and Medicaid Program Integrity Provisions), Pub. L No. 111-148, 124 Stat.

119, 753-56 (2010), amended the Social Security Act by adding a new provision that addresses what constitutes an overpayment under the Federal False Claims Act in the context of a federal health care program. Under this section, an overpayment is defined as "any funds that a person receives or retains under Title XVIII or XIX to which the person, after applicable reconciliation, is not entitled." *See* 42 U.S.C. § 1320a-7k(d)(4)(B). In addition, this provision specifies in relevant part that an "overpayment must be reported and returned" within "60 days after the date on which the overpayment was identified." *Id.* § 1320a-7k(d)(2).

21. Failure to return an overpayment, such as each of the claims on which the Defendants received an overpayment from the CMAP, as alleged herein, constitutes a reverse false claim action under Conn. Gen. Stat. §§ 4-275 (a)(7) and (a)(8).

THE SCHEME – A PERVASIVE PATTERN OF FRAUD

22. During the relevant time period Defendant Mansourov operated a medical practice in Norwalk, Connecticut, known as Family Health Urgent Care Center, Inc. (FHUC). On information and belief, Defendant Mansourov is the sole owner of FHUC. FHUC is primarily a walk-in primary care medical practice located in a strip mall.

23. Defendant Mansourov LLC, as the billing provider, submitted claims to CMAP for the services purportedly performed for Medicaid patients by Defendant Mansourov and by other providers at FHUC. All but a small fraction of these claims were for medical services purportedly performed by Defendant Mansourov.

24. Defendant Mansourov LLC regularly received payments from Medicaid by electronic funds transfer as reimbursement for the claims it submitted for medical services. Defendant Mansourov periodically transferred a small fraction of the Medicaid receipts from

Defendant Mansourov LLC's bank account to FHUC's bank account to cover some of FHUC's operating expenses.

25. During the relevant time period the Department reimbursed Defendants a total of at least $5.2 million.

26. From approximately November 2013 through at least October 2016, Defendant Mansourov and Defendant Mansourov LLC systematically and wantonly fabricated and submitted thousands of false and fraudulent claims to DSS for medical services that Defendant Mansourov purported to have performed but in fact never rendered to CMAP beneficiaries.

27. Defendant Mansourov purported to have performed these services primarily at FHUC's Norwalk office, but also at patient residences and long term care facilities in Connecticut.

28. Defendant Mansourov, individually and through Defendant Mansourov LLC, billed these phony claims to CMAP, usually using billing codes that reimbursed him at the highest rates paid by CMAP for the most complex evaluation and management services purportedly provided at these locations.

29. Defendants submitted thousands of claims for the services Defendant Mansourov purported to have rendered, and received payment for them from CMAP, even though Defendant Mansourov rendered no services and did not treat these patients on the dates of services delineated on the claim forms.

30. Specifically, the following are examples of patients for whom Defendant Mansourov submitted false claims:

A. Defendants billed CMAP and received more than $68,000 for medical services Defendant Mansourov purported to have rendered to Patient A during 362 visits to Patient A's

home. Defendant Mansourov never provided these services to Patient A, but Defendants billed and received payment from CMAP for these false claims.

B. Defendants billed CMAP and received more than $28,000 for medical services Defendant Mansourov purported to have rendered to Patient B during 181 visits to Defendant Mansourov's office. Defendant Mansourov never provided these services to Patient B, but Defendants billed and received payment from CMAP for these false claims.

C. Defendants billed CMAP and received more than $80,000 for medical services Defendant Mansourov purported to have rendered to Patient C during at least 500 visits to Defendant Mansourov's office. Defendant Mansourov never provided these services to Patient C, but Defendants billed and received payment from CMAP for these false claims.

31. On many of the dates of service Defendant Mansourov billed CMAP for services he purportedly provided to Medicaid patients in Connecticut, he in fact was working at various urgent care facilities in Kentucky or was vacationing in Florida, the Dominican Republic, Italy and other destinations.

32. On many of the dates of service Defendant Mansourov billed CMAP for services he purportedly provided to Medicaid patients at FHUC's Norwalk office, at patient residences in Fairfield County, and at long term care facilities in Connecticut, the Medicaid beneficiaries were in-patients admitted at acute care hospitals, and therefore could not have been seen by the Defendant Mansourov at his office, their residences, or long term care facilities.

Fabrication of Patient Records to Conceal the Fraud and Retain the Overpayments

33. On or about January 13, 2015, DSS requested the Defendants to provide the medical records of fifteen patients of Defendant Mansourov documenting the services he purportedly rendered to these patients for various dates of service in 2014.

34. During 2014 the Defendants submitted claims to Medicaid for services purportedly rendered to these fifteen patients, and DSS paid the Defendants for these claims.

35. During February 2015, in response to the Department's request for the patient records, Defendant Mansourov provided the Department with the medical records for the fifteen patients. A large majority of the patient medical records contained fabricated entries intended to substantiate the Defendants' billings.

36. Specifically, Defendant Mansourov fabricated the vast majority of these records in order to provide DSS with a medical record for each date of services he billed and had received payment for, even though he did not treat or provide any services to these patients on most of those dates.

37. The Defendants knew that DSS auditors would consider the absence of a medical record documenting the services that were delineated on the claims submitted to CMAP, if known by CMAP, as a material omission.

38. The Defendants fabricated the medical records and provided them to DSS in order to conceal the fraudulently obtained payments from DSS, to retain the payments he had received, and to avoid the obligation to repay these monies to DSS.

Medicaid Beneficiary Fraud

39. In the calendar years 2014, 2015, and 2016, Defendant Mansourov submitted to CMAP enrollment applications in order to obtain Medicaid benefits for himself and his two minor children.

40. Defendant Mansourov reported on his application for Medicaid benefits a net monthly income of $-4,508 for 2014, $-4,508 for 2015, and $2,750 for 2016.

41. The information Defendant Mansourov reported to CMAP on his enrollment application regarding his net monthly income for 2014, 2015, and 2016 was false. In fact, his net income was much higher, far exceeding the maximum income levels allowed for him and his children to qualify for Medicaid. In addition to Defendant Mansourov's income from private health insurance payments and cash payments from his patients, during 2014, 2015, and 2016, Defendant Mansourov received payments from CMAP for the false claims he submitted of at least $4 million.

42. Defendant Mansourov made his false representation to CMAP regarding his net income in order to induce CMAP to provide Medicaid benefits to him and his two minor children.

43. CMAP enrolled Defendant Mansourov and his two minor children in the Medicaid program because the net monthly income he stated on his enrollment applications fell within the income eligibility requirements for enrollment and receipt of benefits.

44. CMAP would not have enrolled Defendant Mansourov and his two minor daughters in the Medicaid program and provided them with Medicaid benefits if he had stated his true net monthly income on the enrollment application.

45. During the period from 2014 through at least 2016, providers enrolled in CMAP submitted claims to the Medicaid program for healthcare services furnished to Defendant Mansourov and his two minor children.

46. From 2014 through 2016 CMAP paid for Medicaid benefits for Defendant Mansourov and his two minor children for goods provided and services rendered to them in the amount of at least $13,000.

47. Defendant Mansourov LLC purportedly provided some of these medical services. Defendant Mansourov LLC billed and received payment from CMAP in the amount of at least $7,400 for medical services purportedly rendered to Defendant Mansourov and his two minor children, purportedly by Defendant Mansourov and other medical providers at FHUC.

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

48. The allegations of paragraphs 1 — 47 of this Complaint are incorporated herein as allegations of Count One as if fully set forth herein.

49. Connecticut General Statutes § 4-275(a)(1) prohibits the knowing presentation to an officer or employee of the state of a false or fraudulent claim for payment or approval under a state- administered health or human services program.

50. From November 2013 through October 2016 the Defendants knowingly presented or caused to be presented, to an officer or employee of the state, false or fraudulent claims for payment or approval under a state- administered health or human services program.

51. From November 2013 through October 2016 the Defendants knowingly engaged in a long-term pattern and practice of submitting false claims to DSS for services Defendant Mansourov purportedly performed but in fact never rendered.

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

53. Defendants are jointly and severally 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 for each false claim presented or caused to be presented by Defendants.

<u>COUNT TWO –Use of False Records or Statements to Secure Payment - Conn. Gen. Stat. § 4-275(a)(2)</u>

54. The allegations of paragraphs 1 — 47 of this Complaint are incorporated herein as allegations of Count Two as if fully set forth herein.

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

56. From November 2013 through October 2016 the Defendants knowingly made, used or caused to be made or used, false records or statements of services never provided to secure the payment or approval by the state of false or fraudulent claims under a state- administered health or human services program.

57. By virtue of the false records or false statements made, used, or caused to be made or used by the Defendants, the State has suffered damages.

58. Defendants are jointly and severally 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 for each false record or statement or claim presented or caused to be presented by Defendants.

COUNT THREE –Making and Using a False Record Material to An Obligation to Pay Back An Overpayment - Conn. Gen. Stat. § 4-275(a)(7)

59. The allegations of paragraphs1 — 47 of this Complaint are incorporated herein as allegations of Count Three as if fully set forth herein.

60. Pursuant to Connecticut General Statutes § 4-275(a)(7) no person shall knowingly make, use, or cause to be made or used, a false record or statements material to an obligation to pay money to the state under a state- administered health or human services program.

61. From November 2013 through October 2016 the Defendants knowingly made, used or caused to be made or used, a false record or statement of services never provided which were material to an obligation to repay the state an overpayment under a state- administered health or human services program.

62. By virtue of the false records or false statements made, used, or caused to be made or used by the Defendants, the State has suffered damages.

63. Defendants are jointly and severally 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 for each false record or statement or claim presented or caused to be presented by Defendants.

COUNT FOUR –Concealing An Obligation to Pay Back An Overpayment - Conn. Gen. Stat. § 4-275(a)(8)

64. The allegations of paragraphs 1 — 47 of this Complaint are incorporated herein as allegations of Count Four as if fully set forth herein.

65. Pursuant to Connecticut General Statutes § 4-275(a)(8), no person shall knowingly conceal or knowingly and improperly avoid an obligation to pay money to the state under a state-administered health or human services program.

66. From November 2013 through October 2016 the Defendants knowingly concealed or knowingly and improperly avoided an obligation to repay the state an overpayment they received under a state- administered health or human services program.

67. The State has suffered damages due to the Defendants' knowing concealment or knowing and improper avoidance of their obligation to repay the state an overpayment they received under a medical assistance program administered by DSS.

68. Defendants are jointly and severally 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 for each false record or statement or claim presented or caused to be presented by Defendants.

PRAYER FOR RELIEF

WHEREFORE, pursuant to Conn. Gen. Stat. § 4-275(b), the STATE OF CONNECTICUT requests the following relief:

1. 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, 28 U.S.C. § 2461, for each violation of the Act;

2. Three times the amount of damages that the State of Connecticut sustained because of the acts of Defendants, jointly and severally;

3. Costs of investigation and prosecution of this action; and

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

Dated at Hartford, Connecticut, this 10 day of July, 2017.

PLAINTIFF
STATE OF CONNECTICUT

BY: GEORGE JEPSEN
ATTORNEY GENERAL

Michael E. Cole (Juris #417145)
Assistant Attorney General
Chief, Government Program Fraud Department
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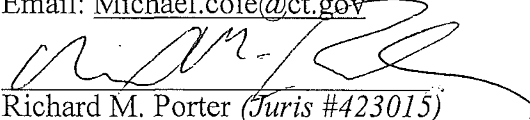

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RETURN DATE: AUGUST 22, 2017

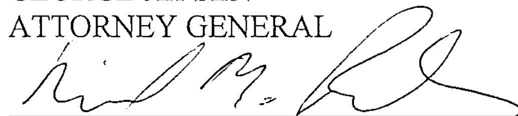
STATE OF CONNECTICUT, *Plaintiff*	:	SUPERIOR COURT
	:	
v.	:	JUDICIAL DISTRICT OF HARTFORD
	:	
RAMIL MANSOUROV AND RAMIL MANSOUROV, LLC *Defendants*	:	JULY 10, 2017

STATEMENT OF AMOUNT IN DEMAND

The amount, legal interest or property in demand is fifteen thousand dollars or more, exclusive of interest and costs, in addition to other relief.

PLAINTIFF
STATE OF CONNECTICUT

BY: GEORGE JEPSEN
ATTORNEY GENERAL



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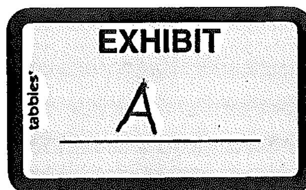

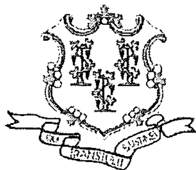

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
Medical Care Administration
Provider Enrollment Agreement

Ramil Mansourov,
(Name of Applicant)

(hereinafter the "Provider") wishes to participate in the Connecticut Medical Assistance Program. For purposes of this Provider Enrollment Agreement (hereinafter the "Agreement"), the term "Connecticut Medical Assistance Program" means any and all of the health benefit programs administered by the State of Connecticut Department of Social Services (hereinafter "DSS"). The Provider represents and agrees as follows:

General Provider Requirements

1. To comply continually with all enrollment requirements established under rules adopted by DSS or any successor agency, as they may be amended from time to time.

2. To abide by and comply with all federal and state statutes, regulations, and policies pertaining to Provider's participation in the Connecticut Medical Assistance Program, as they may be amended from time to time.

3. To continually adhere to professional standards governing medical care and services and to continually meet state and federal licensure, accreditation, certification or other regulatory requirements, including all applicable provisions of the Connecticut General Statutes and any rule, regulation or DSS policy promulgated pursuant thereto and certification in the Medicare program, if applicable.

4. To furnish all information requested by DSS specified in the Provider Enrollment Agreement and the Application Form, and, further, to notify DSS or its designated agent, in writing, of all material and/or substantial changes in information contained on the Application Form.

   To furnish material and/or substantial changes in information including changes in the status of Medicare, Medicaid, or other Connecticut Medical Assistance program eligibility, provider's license, certification, or permit to provide services in/for the State of Connecticut, and any change in the status of ownership of the Provider, if applicable.

5. To provide services and/or supplies covered by Connecticut's Medical Assistance Program to eligible clients pursuant to all applicable federal and state statutes, regulations, and policies.

6. To maintain a specific record for each client eligible for the Connecticut Medical Assistance Program benefits, including but not limited to name; address; birth date; Social Security Number; DSS identification number; pertinent diagnostic information including x-rays; current treatment plan; treatment notes; documentation of dates of services and services provided; and all other information required by state and federal law.

7. To maintain all records for a minimum of five years or for the minimum amount of time required by federal or state law governing record retention, whichever period is greater. In the event of a dispute concerning goods and services provided to a client, or in the event of a dispute concerning reimbursement, documentation shall be maintained until the dispute is completely resolved or for five years, whichever is greater.

   The Provider acknowledges that failure to maintain all required documentation may result in the disallowance and recovery by DSS of any amounts paid to the Provider for which the required documentation is not maintained and provided to DSS upon request.

8. To maintain, in accordance with the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §§ 1320d to 1320d-8, inclusive, and regulations promulgated thereto, as they may be amended from time to time, the confidentiality of a client's record, including, but not limited to:

a. client's name, address, and Social Security number;

b. medical services provided;

c. medical data, including diagnosis and past medical history;

d. any information received for verifying income eligibility; and

e. any information received in connection with the identification of legally liable third party resources.

Disclosure of clients' personal, financial, and medical information may be made under the following circumstances:

f. to other providers in connection with their treatment of the client;

g. to DSS or its authorized agent in connection with the determination of initial or continuing eligibility, or for the verification or audit of submitted claims;

h. in connection with an investigation, prosecution, or civil, criminal, or administrative proceeding related to the provision of or billing for services covered by the Connecticut Medical Assistance Program;

i. as required to obtain reimbursement from other payer sources;

j. as otherwise required by state or federal law; and

k. with the client's written consent to other persons or entities designated by the client or legal guardian, or, in the event that the client is a minor, from the client's parents or legal guardian.

Upon request, disclosure of all records relating to services provided and payments claimed must be made to the Secretary of Health and Human Services; to DSS; and/or to the State Medicaid fraud control unit, in accordance with applicable state and federal law.

In the event that the Provider authorizes a third party to act on the Provider's behalf, the Provider shall submit written verification of such authorization to DSS.

9. To maintain a written contract with all subcontractors which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract, and, in accordance with 42 C.F.R. § 455.105 and § 431.115 et seq., to provide upon request of the Secretary of Health and Human Services and/or DSS, full and complete information about the ownership of any subcontractor or any significant business transaction.

   No subcontract, however, terminates the legal responsibility of the Provider to DSS to assure that all activities under the contract are carried out. Provider shall furnish to DSS upon request copies of all subcontracts in which monies covered by this Agreement are to be used. Further, all such subcontracts shall include a provision that the subcontractor will comply with all pertinent requirements of this Agreement.

10. To abide by the DSS' Medical Assistance Program Provider Manual(s), as amended from time to time, as well as all bulletins, policy transmittals, notices, and amendments that shall be communicated to the Provider, which shall be binding upon receipt unless otherwise noted. Receipt of amendments, bulletins and notices by Provider shall be presumed when the amendments, bulletins, and notices are mailed or emailed to the Provider's current address or email address that is on file with DSS or its fiscal agent, or posted to the Connecticut Medical Assistance Program web site.

11. To make timely efforts to determine clients' eligibility, including verification of third-party payor resources, and to pursue insurance, Medicare and any other third party payor prior to submitting claims to the Connecticut Medical Assistance Program for payment.

    Provider further acknowledges the Connecticut Medical Assistance Program as payor of last resort. Provider agrees to exhaust clients' medical insurance resources prior to submitting claims for reimbursement and to assist in identifying other possible sources of third party liability, which may have a legal obligation to pay all or part of the medical cost of injury or disability.

12. To comply with the advance directives requirements set forth specified in 42 C.F.R. Part 489, Subpart I, and 42 C.F.R. § 417.436(d), if applicable.

Billing/Payment Rates

13. To submit timely billing in a form and manner approved by DSS, as outlined in the Provider manual, after first ascertaining whether any other insurance resources may be liable for any or all of the cost of the services rendered and seeking reimbursement from such resource(s).

14. To comply with the prohibition against reassignment of provider claims set forth in 42 C.F.R. § 447.10.

15. To submit only those claims for goods and services that are covered by the Connecticut Medical Assistance Program and that are documented by Provider as being:
    a. for medically necessary goods and services;
    b. for medically necessary goods and services actually provided to the person in whose name the claim is being made;
    c. for compensation that Provider is legally entitled to receive; and
    d. in compliance with DSS requirements regarding timely filing.

16. To accept payment as determined by DSS or its fiscal agent in accordance with federal and state statutes and regulations and policies as payment in full for all services, goods, and products covered by Connecticut Medical Assistance Program and provided to program clients. The Provider agrees not to bill program clients for services that are incidental to covered services, including but not limited to, copying medical records and completing school and camp forms and other forms relating to clients' participation in sports and other activities. The Provider further agrees not to bill clients or any other party for any additional or make-up charge for services covered by the Connecticut Medical Assistance Program, excluding any cost sharing, as defined in section 17b-290(6) of the Connecticut General, and as permitted by law, even when the Program does not pay for those covered services for technical reasons, such as a claim not timely filed or a client being managed-care eligible, or a billed amount exceeding the program allowed amount. The provider may charge an eligible Connecticut Medical Assistance Program client, or any financially responsible relative or representative of that individual, for goods or services that are not covered under the Connecticut Medical Assistance Program, only when the client knowingly elects to receive the goods or services and enters into an agreement in writing for such goods or services prior to receiving them.

    The Provider shall refund to the payor any payment made by or on behalf of a client determined to be eligible for the Connecticut Medical Assistance Program to the extent that eligibility under the program overlaps the period for which payment was made and to the extent that the goods and services are covered by Connecticut Medical Assistance Program benefits.

17. To timely submit all financial information required under federal and state law.

18. To refund promptly (within 30 days of receipt) to DSS or its fiscal agent any duplicate or erroneous payment received, including any duplication or erroneous payment received for prior years or pursuant to prior provider agreements.

19. To make repayments to DSS or its fiscal agent, or arrange to have future payments from the DSS program(s) withheld, within 30 days of receipt of notice from DSS or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made. This obligation includes repayment of an overpayment received for prior years or pursuant to prior provider agreements. The Provider is liable for any costs incurred by DSS in recouping any overpayment.

20. To promptly make full reimbursement to DSS or its fiscal agent of any federal disallowance incurred by DSS when such disallowance relates to payments previously made to Provider under the Connecticut Medical Assistance Program, including payments made for prior years or pursuant to prior provider agreements.

21. To maintain fiscal, medical and programmatic records which fully disclose services and goods rendered and/or delivered to eligible clients. These records and information, including, but not limited to, records and information regarding payments claimed by the Provider for furnishing goods and services, will be made available to authorized representatives upon request, in accordance with all state and federal statutes and regulations.

22. To cooperate fully and make available upon demand by federal and state officials and their agents all records and information that such officials have determined to be necessary to assure the appropriateness of DSS payments made to Provider, to ensure the proper administration of the Connecticut Medical Assistance

Program and to assure Provider's compliance with all applicable statutes and regulations and policies. Such records and information are specified in federal and state statutes and regulations and the Provider Manual and shall include, without necessarily being limited to, the following:

a. medical records;

b. original prescriptions for and records of all treatments, drugs and services for which vendor payments have been made, or are to be made under the Connecticut Medical Assistance Program, including the authority for and the date of administration of such treatment, drugs, or services;

c. any original documentation determined by DSS or its representative to be necessary to fully disclose and document the medical necessity of and extent of goods or services provided to clients receiving assistance under the provisions of the Connecticut Medical Assistance Program;

d. any other original documentation in each client's record which will enable the DSS or its agent to verify that each charge is due and proper;

e. financial records maintained in accordance with generally accepted accounting principles, unless another form is specified by DSS; and

f. all other records as may be found necessary by DSS or its agent in determining Provider's compliance with any federal or state law, rule, regulation, or policy.

23. That any payment, or part thereof, for Connecticut Medical Assistance Program goods or services, which represent an excess over the appropriate payment, or any payment owed to DSS because of a violation due to abuse or fraud, shall be immediately paid to DSS. Any sum not so repaid may be recovered by DSS in accordance with the provisions below or in an action by DSS brought against the Provider.

24. To pay any applicable application fee, as required under federal law.

Audits and Recoupment

25. That in addition to the above provisions regarding billing and payment, Provider agrees that:

a. amounts paid to Provider by DSS shall be subject to review and adjustment upon audit or due to other acquired information or as may otherwise be required by law;

b. whenever DSS makes a determination, which results in the Provider being indebted to the DSS for past overpayments, DSS may recoup said overpayments as soon as possible from the DSS's current and future payments to the Provider. DSS's authority to recoup overpayments includes recoupment of overpayments made for prior years or pursuant to prior provider agreements. A recomputation based upon such adjustments shall be made retroactive to the applicable period;

c. in a recoupment situation, DSS may determine a recoupment schedule of amounts to be recouped from Provider's payments after consideration of the following factors:

(1) the amount of the indebtedness;

(2) the objective of completion of total recoupment of past overpayments as soon as possible;

(3) the cash flow of the Provider; and

(4) any other factors brought to the attention of DSS by the Provider relative to Provider's ability to function during and after recoupment;

d. whenever Provider has received past overpayments, the DSS may recoup the amount of such overpayments from the current and future payments to Provider regardless of any intervening change in ownership;

e. if Provider owes money to DSS, including money owed for prior years or pursuant to prior provider agreements, DSS or its fiscal agent may offset against such indebtedness any liability to another provider which is owned or controlled by the same person or persons who owned or controlled the first provider at the time the indebtedness to DSS was incurred. In the case of the same person or persons owning or controlling two or more providers but separately incorporating them, whether the person or persons own or control such corporations shall be an issue of fact. Where common ownership or control is found, this

subsection shall apply notwithstanding the form of business organizations utilized by such persons e.g. separate corporations, limited partnerships, etc.; and

f. DSS's decision to exercise, or decision not to exercise, its right of recoupment shall be in addition to, and not in lieu of, any other means or right of recovery the DSS may have.

Fraud and Abuse; Penalties

26. To cease any conduct that DSS or its representative deems to be abusive of the Connecticut Medical Assistance Program and to promptly correct any deficiencies in Provider's operations upon request by DSS or its fiscal agent.

27. To comply with state and federal law, including, but not limited to, sections 1128, 1128A, 1128B, and 1909 of the Social Security Act (hereinafter the "Act") (42 U.S.C. §§ 1320a-7, 1320a-7a, 1320a-7b,1396h) and Connecticut General Statutes sections 17b-301a to 17b-301p, inclusive, which provide state and federal penalties for violations connected with the Connecticut Medical Assistance Program.

    Provider acknowledges and understands that the prohibitions set forth in state and federal law include, but are not limited to, the following:

    a. false statements, claims, misrepresentation, concealment, failure to disclose and conversion of benefits;
    b. any giving or seeking of kickbacks, rebates, or similar remuneration;
    c. charging or receiving reimbursement in excess of that provided by the State; and
    d. false statements or misrepresentation in order to qualify as a provider.

28. That termination from participation in the Connecticut Medical Assistance Program will result if the Provider is terminated on or after January 1, 2011 under Title XVIII of the Act (Medicare) or any other state's Title XIX (Medicaid) program or Title XXI (CHIP); is convicted of a criminal offense related to that person's involvement with Medicare, Medicaid or Title XXI programs in the last ten years; or if the Provider fails to submit timely and accurate information and cooperate with any screening methods required by law.

29. That suspension may result if the Provider is sanctioned by DSS for having engaged in fraudulent or abusive program practices or conduct, as set forth in state or federal law.

30. That, in accordance with federal law, DSS must temporarily suspend all Medicaid payments to a Provider after it determines there is a credible allegation of fraud for which an investigation is pending, unless DSS has good cause to not suspend payments or to suspend only in part.

31. <u>To comply with the provisions of section 1902(a)(68) of the Act (42 U.S.C. § 1396a(a)(68)) and sections 17b-262-770 to17b-262-773, inclusive, of the Regulations of Connecticut State Agencies, as they may be amended from time to time.</u>

Nondiscrimination

32. To abstain from discrimination or permitting discrimination against any person or group of persons on the basis of race, color, religious creed, age, marital status, national origin, ancestry, sex, gender identity or expression, sexual orientation, mental retardation, mental or physical disability, including, but not limited to, blindness or payor source, in accordance with the laws of the United States or the State of Connecticut.

    Provider further agrees to comply with:

    a. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000d, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the regulations, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal Financial Assistance from the Department of Health and Human Services;
    b. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 et seq., (hereafter the "Rehabilitation Act") as amended, and all requirements imposed by or pursuant to the regulations of the Department of

Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of the Rehabilitation Act and the regulations, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal Financial Assistance from the Department of Health and Human Services;

c. Title IX of the Educational Amendments of 1972, 20 U.S.C. § 1681, et seq., as amended, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the regulations, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any educational program or activity for which the Applicant receives Federal Financial Assistance from the Department of Health and Human Services; and

d. the civil rights requirements set forth in 45 C.F.R. Parts 80, 84, and 90.

Termination

33. That this Agreement may be voluntarily terminated as follows:

a. by DSS or its fiscal agent upon 30 days written notice;

b. by DSS or its fiscal agent upon notice for Provider's breach of any provision of this Agreement as determined by DSS; or

c. by Provider, upon 30 days written notice, subject to any requirements set forth in federal and state law. Compliance with any such requirements is a condition precedent to termination.

Disclosure Requirements

34. To comply with all requirements, set forth in 42 C.F.R. §§ 455.100 to 455.106, inclusive, as they may be amended from time to time. These requirements include, but are not limited to, the full disclosure of the following information upon request:

a. the name, address, social security number and date of birth of any provider or any individual or managing employee (or tax identification number in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more;

b. whether any such person is related to another as spouse parent, child, or sibling;

c. the name of any other disclosing entity in which such a person also has an ownership or control interest;

d. the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000.00 during the 12-month period ending on the date of the request;

e. any significant business transactions between Provider and any subcontractor during the 5-year period ending on the date of the request;

f. the name of any person having an ownership or control interest in Provider, or as an agent or managing employee of Provider, who has been convicted of a civil or criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or other Connecticut Medical Assistance Programs since the inception of these programs; and

g. any other information requested in the Provider Enrollment application.

Provider further agrees to furnish, without a specific request by DSS, the information referenced above at the time of Provider's certification survey, as applicable, and also, without a specific request, disclose the identity of any person with ownership or control interest who has been convicted of a civil or criminal offense related to that person's involvement in any program under Medicare, Medicaid, or other Connecticut Medical Assistance Programs prior to entering into or renewing this Agreement in accordance with 42 C.F.R. Part 455.

35. That the following penalties, as set forth in 42 C.F.R. §§455.104 to 455.106, inclusive, are applicable to Providers failing to make that section's required disclosures:

a. DSS will not approve an Agreement and must terminate an existing Agreement if the Provider fails to disclose ownership or control information;
b. DSS may refuse to enter into or renew an Agreement with a Provider if any person with ownership or interest control, or who is an agent or a managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the Title XX Services Program;
c. DSS may refuse to enter into or terminate an Agreement if it determines that a Provider did not fully and accurately make the required disclosures concerning such convictions.

Miscellaneous

36. That the Agreement, upon execution, supersedes and replaces any Agreement previously executed by the Provider. This Agreement does not impair Provider's obligation to repay to DSS any money owed to DSS pursuant to prior Agreements or the ability of DSS to recoup such amounts from payments made pursuant to this Agreement.

37. The Provider acknowledges that there is no right to renew this Agreement.

38. The Provider will examine publicly available data, including but not limited to the U.S. Department of Health and Human Services Office of Inspector General (hereinafter "OIG"), or any successor agency's, List of Excluded Individuals/Entities Report and the OIG Web site, to determine whether any potential or current employees, contractors or suppliers have been suspended or excluded or terminated from any healthcare program and shall comply with, and give effect to, any such suspension, exclusion, or termination or accordance with the requirements of state and federal law. The Provider shall search the HHS-OIG Web site on a monthly basis, or at such intervals as specified by the OIG or DSS, to capture sanctions that have occurred since the Provider's last search. The Provider shall also routinely search the Administrative Actions List on the DSS website. The Provider shall immediately report to the OIG and to DSS any sanction information discovered in its search and report what action has been taken to ensure compliance with state and federal law. The Provider shall be subject to civil monetary penalties if it employs or enters into contracts with excluded individuals or entities.

39. If the provider uses electronic signatures, the provider certifies that the provider's policies meet the DSS requirements for acceptance, issuance, and use of electronic signatures.

The effective date of this Agreement and the period of time during which this Agreement shall be in effect, unless terminated by either party prior to the stated ending date, shall be written on the letter DSS sends to the Provider, through its Fiscal Agent Contractor, approving the Provider for participation in the Connecticut Medical Assistance Program. This approval letter shall be incorporated into and made part of this Agreement. If the Provider fails to complete an application for re-enrollment by the time the current Agreement has expired, DSS may stop making payments to the Provider, although DSS will retroactively make payments for services provided under the Connecticut Medical Assistance Program for up to six months from the date the re-enrollment was due.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE, BOTH INDIVIDUALLY AND ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.

THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID RELATED OFFENSE AS SET OUT IN 42 U.S.C. § 1320a-7b MAY BE PUNISHABLE BY A FINE OF UP TO $25,000 OR IMPRISONMENT OF UP TO FIVE YEARS OR BOTH.

Ramil Mansourov
Provider Entity Name (doing business as);

Ramil mansourov

Name of Authorized Representative (typed) (Must be an Authorized Officer, Owner, or Partner):

Ramil mansourov

Signature of Authorized Representative