IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

[UNDER SEAL], *ex. rel.* [UNDER SEAL],

Plaintiff,

v.

[UNDER SEAL],

Defendants.

Case No. 21-STCV-00923

[FILED UNDER SEAL PURSUANT TO THE FALSE CLAIMS ACT, CALIFORNIA INSURANCE CODE SECTION 1871.7]

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****FILED UNDER SEAL PURSUANT TO CAL. INS. CODE 1871.7**

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES

THE STATE OF CALIFORNIA, *ex. rel.* AMERICAN INTEGRA LLC
Plaintiff,
v.

STERLING PATHOLOGY MEDICAL CORPORATION, doing business as STERLING PATHOLOGY NATIONAL LABORATORIES, (also known as STERLING PATHOLOGY MEDICAL GROUP);

CHANGGAO YANG, M.D. (also known as CHANG GAO YANG, and CHENGGAO YANG);

MICHAEL OKUNIEWSKI;

ELLIE LEKOV, M.D. (also known as ELLIE SUVOUZ LEKOV, and ELI LEKOV);

ELITE MEDICAL BILLING CORPORATION;

JENNY CHANG, a.k.a JENNY AU;

and DOES 1-10,

Defendants.

Case No. 21-STCV-00923
JUDGE Hon. Maureen Duffy-Lewis

FIRST AMENDED COMPLAINT FOR TREBLE DAMAGES AND CIVIL PENALTIES FOR VIOLATION OF THE CALIFORNIA INSURANCE FRAUDS PREVENTION ACT ("IFPA") PURSUANT TO CALIFORNIA INSURANCE CODE §1871 ET. SEQ.

1. **VIOLATION OF THE IFPA-FALSE MEDICAL CLAIMS**
2. **VIOLATION OF THE IFPA- USE OF RUNNERS AND CAPPERS TO PROCURE COVID-19 TESTING**
3. **MAKING FALSE RECORD MATERIAL TO OBLIGATION TO PAY**
4. **CONSPIRACY TO VIOLATE THE IFPA**
5. **UNJUST ENRICHMENT**

DEMAND FOR JURY TRIAL

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FIRST AMENDED COMPLAINT FOR DAMAGES

COMES NOW Plaintiff, the State of California (hereinafter the "State") by and through the Insurance Commissioner and California Department of Insurance (hereinafter CDI), by and through relator American Integra LLC (Relator) and the undersigned counsel, allege as follows against Defendants (collectively herein Sterling):

This First Amended Complaint (FAC) for violation of the California Insurance Frauds Prevention Act (IFPA) codified by Cal. Insurance Code §1871.7 et seq. is filed *under seal* on behalf of Plaintiff, the State.

I. SUMMARY

1. This action is brought against Defendants Sterling Pathology Medical Corporation (Sterling) and Elite Medical Billing Corporation (Elite), who knowingly engaged in unlawful laboratory billing practices and illicit marketing. These actions are in violation of the California Insurance Frauds Prevention Act (IFPA) pursuant to Cal. Insurance Code 1871 et. seq.

2. For the better part of a decade, Defendants have surreptitiously submitted hundreds of thousands of false claims to commercial carriers of this State including Blue Cross, Blue Shield, United Healthcare, Cigna, Aetna, Humana, and others for unnecessary, unbundled, and upcoded Pathology "special stains" which in many cases were never ordered by the treating physician and never performed.

3. As this country struggled to cope with a devastating pandemic, these Defendants also conspired further to swindle insurance providers out of millions of dollars. They engaged in illicit COVID-19 test billing using unlawful contracted cappers, runners, and kickbacks to obtain patients' insurance information, dates of birth, and driver's licenses for unearned payments under the COVID emergency payments including those provided under the COVID-19 CARES Act and the "HRSA COVID-19 Uninsured Program." They exploited the healthcare system when it was at its most vulnerable, indirectly raising healthcare costs for everyday Americans.

4. Defendants accessed private patient information – including names, dates of birth, and insurance subscriber numbers – through various marketers and cappers. They then used the patient information to submit false claims to insurance providers for fake COVID-19 testing that was never performed, and results never given to patients or their physicians.

5. These unlawful and false healthcare claims submitted by Defendants have led to tens of millions of dollars in undeserved overpayments from the State's carriers, undermining the integrity of our healthcare system and misappropriating state funds.

6. Under California law, patients are entitled to receive care necessary for their clinical needs, not for the financial gains of their healthcare providers. These provisions, along with the IFPA, hold healthcare providers accountable if they bill for unnecessary services or treatment, manipulate billing through unbundling and upcoding, or obtain insurance proceeds by engaging in illicit marketing practices.

7. Defendants systematically exploited a well-known self-referral loophole in the billing process for Pathology special stains for insurance beneficiaries, in violation of the IFPA. They falsified physician names on final pathology reports and used unlicensed staff or medical providers not authorized to practice medicine in California. This manipulation allowed Defendants to generate millions in unearned revenues.

8. Defendants further exploited the COVID-19 pandemic by mass billing for COVID-19 testing, using illicit marketing and kickbacks. They leveraged lucrative loopholes and reimbursements in emergency laboratory test payment programs, accruing tens of millions of dollars in improper revenues through insurance relief programs.

9. Since at least 2013, Sterling and Elite have reaped profits from their false and predatory laboratory billing practices. They submitted countless false claims for payment for medically unnecessary "special stain" Pathology services and COVID-19 testing procured through unlawful use of cappers and runners, in violation of the IFPA. Sterling's billing patterns and high frequency of certain special stain billing codes reveal a reliable indication of fraud.

10. This case, under IFPA, seeks to hold Defendants accountable for their widespread laboratory testing fraud. Supported by exemplar patient records, Sterling generated special stain reports, and Elite billing documents, this Complaint demonstrates a pervasive and long-running scheme to defraud the State's carriers.

11. Defendants' deceitful practices, which included cloned test requisitions and reports, fabricated reports, pass-through billing, and kickbacks, targeted California insurance funded patients. Their recent COVID-19 testing schemes deliberately focused on certain immigrant communities — whom Defendants believed were culturally more cooperative and less likely to raise concerns about false claims.

12. Defendants' institutional "upcoding" and "unbundling" schemes violated the IFPA, while providing kickbacks to third-party providers in exchange for large-scale milling and access to beneficiaries' driver's licenses and insurance information violates Cal Ins. Code §1871.7(a) , which prohibits such kick-backs. The scheme resulted in unearned COVID-19 insurance payments for testing which was never performed.

13. Through their fraudulent business model, Defendants Sterling and Elite amassed astonishing revenues, undermining the trust and financial stability of the State's healthcare programs. Defendants' actions not only violated multiple state statutes, but also deprived vulnerable patients of much-needed healthcare resources.

14. This case seeks to hold Defendants accountable for their unlawful actions and recover damages for the State of California. With the evidence gathered, including contracts between Sterling and its illicit marketers, Plaintiff aim sto demonstrate the extent of Defendants' fraudulent practices and secure justice for the state and its taxpayers.

15. Damages to the State are estimated in excess of $18.5 million, exclusive of the statutory § 1871.7 damages, and Penal Code section 550 penalties of $10,000 per false claim, plus an assessment of three times the amount of each claim for compensation sustained because of Defendants' fraudulent acts.

II. JURISDICTION AND VENUE

16. This Court has original subject matter jurisdiction over this action pursuant to Cal. Ins. Code §1871.7.

17. Venue is also proper because one or more Defendants reside in this County and all Defendants are residents of the State of California, and because a substantial part of the events or omissions giving rise to the claims alleged occurred in this County.

18. This Court has personal jurisdiction over Defendants and venue is proper in this District because Defendants can be found in, reside, and/or transact business in this District, and because acts proscribed by Cal. Ins. Code §1871.7 occurred in this District.

Relator's Direct and Independent Knowledge

19. Relator has served upon the required parties including the Attorney General of the State of California, the California Department of Insurance, and the County District Attorney's Office the Complaint and a written disclosure statement summarizing the known material evidence and information in the possession of Relator related to the original Complaint, in accordance with the provisions of 31 U.S.C. §3730(b)(2). The disclosure statement is supported by material evidence, and documentary evidence has been produced with the disclosure. The documents referenced in the disclosure statement, and those produced in connection therewith or subsequently, are incorporated herein by reference.

20. Relator shall serve upon the required parties or their respective designees a copy of any subsequent amended complaint(s).

21. There has been no statutorily relevant public disclosure of "substantially the same allegations or transactions" alleged in this Complaint. To the extent there has been any such public disclosure, Relator meets the definition of an "original source," as that term is defined. Specifically, Relator voluntarily disclosed to the government the information upon which allegations or transactions at issue in this complaint are based *prior* to any purported public disclosure.

22. Alternatively, Relator has knowledge that is independent of and materially adds to any purported publicly disclosed allegations or transactions, and Relator voluntarily provided the information to the government before filing its complaint. Relator therefore qualifies as an "original source" of the allegations in this Complaint such that the so-called prior disclosure or public disclosure bar even if invoked, would be inapplicable.

III. PARTIES

A. Plaintiff(s)

23. Plaintiff is the State of California who brings this action by and through the California Department of Insurance, pursuant to California Insurance Code Section 1871.7.

24. Plaintiff's Relator, American Integra LLC, is a limited liability company conducting business in the State. Relator brings this action as the Plaintiff's relator as authorized by Section 1871.7 of the Insurance Code to bring a false claims action on behalf of the State. Relator's original source knowledge of the matters giving rise to this action stems from Relator's business transactions with Defendants Sterling and Elite.

B. Defendants

25. Defendant STERLING PATHOLOGY MEDICAL CORPORATION, doing business as STERLING PATHOLOGY NATIONAL LABORATORY and also known as STERLING PATHOLOGY MEDICAL GROUP (collectively "Sterling"), is a for profit professional corporation organized and existing under the laws of the State of California, having its principal place of business in Seal Beach, California.

26. Defendant CHANG GAO YANG, M.D., a.k.a CHANGGAO YANG AND CHENGGAO YANG (Yang) is an individual domiciled in in **Los Angeles County, California.** Yang is the "Chief Executive Officer, Secretary, and Chief Financial Officer" of Sterling, and otherwise the corporate parent of, owns, or otherwise controls Sterling. Yang is licensed as a California physician License No. AG2281 and bills under **NPI 1366435638**.

27. Sterling provides "clinical medical laboratory" services *nationwide,* as credentialed in California, Florida, Maryland, New York, Rhode Island, and Pennsylvania.

Sterling bills for healthcare services under a number of aliases and identifications including National Provider Identifier (NPI) **1174518302**, NPI 1467444893, NPI 1255324018, and Medicare No. HW16573, and MediCal No. A627810.

28. Defendant MICHAEL OKUNIEWSKI (Okuniewski) is an individual domiciled in California, who has been the managing Vice President of Operations and Sales, and the Chief Marketing Officer at Sterling since September 2011.

29. Defendant ELLIE LEKOV, M.D. (Lekov) is an individual domiciled in California, and a managing agent and pathologist having her principal place of business at Sterling. She bills under **NPI 1033266788.**

30. Defendant ELITE MEDICAL BILLING CORPORATION (Elite), a California Corporation Entity No. C3247563 located in Hanford, California, and JENNY CHANG (Chang), an individual (President and founder of Elite) are the principal and sole medical billers for Defendants and receive a sizable percentage of Sterling's earnings.

31. At all times mentioned herein, each defendant was the agent for each other defendant, was acting in the course and scope of such agency and was engaged in a conspiracy to do the things herein alleged.

32. Plaintiffs are informed and believe and, on that basis, allege that at all times relevant herein, Defendants, and each of them, were and remain the alter-egos of each other, that they did and still do dominate, influence and control each other, that there existed and still exists a unity of ownership between them, that the individuality and separateness of each entity was and remains non-existent, that each such entity was and remains a mere shell, conduit and/or naked framework which the other defendants used and still use to conduct their business affairs, and that each such entity was and remains inadequately capitalized, and that an injustice and fraud upon Plaintiffs will result if the theoretical separateness of the defendant entities is not disregarded and each such defendant held liable for all relief being sought herein. Plaintiffs are informed and believe and on that basis alleges that at all times herein, Defendants, and each of them, knowingly and willfully conspired, joined and participated with each other in the conduct alleged in furtherance of

a conspiracy between and among Defendants to enrich themselves at Plaintiffs' expense, and that each such defendant is therefore liable with each other defendant for the conduct herein alleged, for the damages suffered by Plaintiffs and for the relief being sought herein.

33. Plaintiffs are ignorant of the true names and capacities of the defendants sued herein under the fictitious names DOES 1 through 10. Each of the fictitiously named defendants is responsible in some manner for the acts and violations herein alleged. Plaintiffs will seek leave to amend this complaint to allege said defendants' true names and capacities as soon as Plaintiffs ascertain them.

IV. COMMON FACTUAL ALLEGATIONS: BACKGROUND

A. Laboratory Testing

34. 42 CFR §410.32 outlines billing regulations for "…diagnostic laboratory tests, and other diagnostic tests." Section 410.32(a) provides, "…laboratory tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem." "Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary." *Id*.

35. Insurance carriers only pay for medically necessary services that were provided as represented and prohibit claims procured through kickbacks or bribes. Insurance carriers do not cover diagnostic testing, *including Pathology special stain testing,* that is not reasonable and necessary for diagnosis or treatment of illness or injury.

36. If diagnostic testing is necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member, carriers impose additional requirements before covering the testing.

37. Specifically for pathology special stains, the laboratory must have a physician order for the stain, and the orders must not be made until the pathologists first reviews the regularly stained slide. Reflex or auto-ordering of special stains without the prior examination of the slide is prohibited, and also constitutes improper billing. Insurance

carriers will not pay for special stains which do not conform with these mandates and medical necessity requirements.

B. Pathology Billing Codes

38. Pathology services use a set of codes called Current Procedural Terminology (CPT) for billing purposes. These codes, ranging from 80002 to 89399, specify the procedures conducted, with surgical pathology services represented by codes 88300 to 88399.

39. The complexity of the surgical pathology service is reflected in the codes used. For instance, simpler services use the CPT 88302 code, while highly complex ones use CPT 88307. However, pathologists most frequently use CPT codes 88304 or 88305.

40. Routine Hematoxylin and Eosin (H&E) staining, a standard part of pathology services, is included in the billing codes from CPT 88300 to 88309. Therefore, additional charges for routine H&E staining are inappropriate and unwarranted.

41. When cases are complex or results are unclear, pathologists may order additional special stains, represented by CPT codes 88312-88313 and 88341-88344. These special stains incur higher charges than standard pathology services.

42. The Pathology section of the CPT codebook is quite straightforward, consisting of only four pages and listing 44 items. However, despite its brevity, every word and sentence in the procedure descriptors holds significant meaning.

43. In this context, a "specimen" refers to tissue that requires individual examination and diagnosis. Multiple specimens from the same patient, such as separately identified endoscopic biopsies or skin lesions, each receive their own codes based on the level of service provided.

44. The terms "unit of service" and "specimen" are fundamental to understanding CPT coding for surgical pathology. Each separately identified and diagnosed specimen corresponds to a unit of charge.

45. A specimen is typically considered "submitted for individual and separate attention" when it arrives in the lab in a separately labeled container. However, this is not always the case — sometimes, tissues in separate containers must be combined as a single

charge, based on specific rules from the American Medical Association (AMA) or the payer. For a tissue sample to justify a charge, it must be individually diagnosed in the final diagnosis section of the medical report.

C. Pathology Limitations

46. The state's insurance carriers are not required to remit payments for claims lacking the necessary documentation or for services deemed unreasonable or unnecessary. Furthermore, carriers prohibit healthcare payments for inappropriate or automatic/reflex ordering of special stains self-referred by pathologists.

47. The typical billing practice in pathology is a "1 jar, 1 specimen, 1 CPT code" rule. However, some unethical laboratories exploit a known loophole by reflexively billing or excessively using special stain codes to inflate revenue, thereby shifting to a "1 jar, 1 specimen, multiple CPT codes" approach, which can double or triple earnings per specimen.

48. Special stains (coded as CPT 88312-88313, or 88341-88344) should only be used when standard H&E staining cannot provide all the necessary information, and the ordered special stain has a reasonable likelihood of contributing to or being relevant for the final diagnosis.

D. Pathology Payments Slashed Nationally

49. Insurance carriers base their payment schedules on the Centers for Medicare and Medicaid Services' (CMS) publicly available fee schedules for each laboratory service.

50. In 2009, CMS introduced a single payment for multiple prostate saturation biopsy pathology services to address overpayment patterns, which effectively reduced earnings for reading prostate biopsies.

51. In 2013, CMS further reduced all pathology reimbursements to tackle ongoing overbilling issues. This measure approximately halved reimbursement for the technical component (TC), leading to a 30% overall reduction in payment for a global pathology claim.

52. CMS reduced reimbursement for immunohistochemistry special stains by over 30% in 2014 (following consistent increases the previous year). Despite these systematic reductions in pathology reimbursements, starting in 2016, claims and payments for

immunohistochemistry began to rise again, necessitating further measures to ensure appropriate use and to combat overuse and abuse.

53. Around 2011, reimbursements for surgical pathology CPT codes 88300-88399 were significantly reduced, by an average of one-third. This led to substantial revenue losses for pathology labs. For example, reimbursements for pathology code CPT 88305 fell from an average of roughly $200 to $78.65 per specimen by 2019 (source: https://www.palmettogba.com/palmetto/fees_front.nsf/fee_main?OpenForm).

54. Shortly thereafter, both self-referred and non-self-referred special stain usage saw rapid increases, with self-referred special stains growing over 400% between 2004 and 2010. Self-referred special stains (from owner-operator laboratories) increased at a higher rate than non-self-referred special stains. Specifically, the number of *self-referred* special stains rose from about 60,000 in 2004 to about 340,000 in 2010—an increase of more than 400 percent.

E. Pathology Fraud And Abuse[1]

55. When pathology codes 88304-88309 are billed routinely with special stain codes (CPT codes 88312-88313 and 88341-88344), they trigger a Medically Unlikely Edit (MUE), indicating potential billing fraud.

56. The "1 jar, 1 specimen, 1 CPT code" principle covers approximately 95-97% of coding situations. This principle balances aggressive unbundling of codes and cautious bundling.

[1] The Government Accountability Office (GAO) published a general consensus report highlighting the increased use of anatomic pathology services by providers who self-refer, resulting in substantial additional healthcare spending. See https://www.gao.gov/assets/660/655442.pdf The GAO report found that referrals for pathology services significantly increased after owner-operator labs began self-referring.

CMS paid approximately $1.28 billion in 2010 under the physician fee schedule for pathology services across all settings, with nearly 80% ($945 million) performed in physician offices and independent laboratories, like Sterling. The GAO report also found that special stains, used with pathology services, accounted for about 66% of the $1.94 billion spent on these services in 2010, mainly for examining biopsy tissue samples.

57. Routinely billing one special stain CPT code for every specimen or nearly every specimen (a practice seen in Sterling) is a clear example of billing fraud and abuse. Such a practice constitutes a "never" event - a flagrant upcoding and revenue scheme that goes beyond even the MUEs. This overt fraudulent activity fits within the statutory definitions of fraud under the California Insurance Fraud Prevention Act (IFPA).

58. Overbilling for "special stains" by owner-operator labs, such as Sterling, exploits a recognized loophole in the insurance billing algorithm. This type of fraud and abuse is well-known and has led to several successful prosecutions and substantial monetary recoveries under the false claims act.

V. FACTS COMMON TO ALL COUNTS

59. Sterling, one of the most profitable Pathology laboratories in California *and* the United States, has consistently earned rank in the 99th percentile since at least January 9, 2013. Sterling and its CEO Yang are also ranked at the 99th percentile compared to all other approximately 1000 pathologists in this State.

60. While remarkable profits are not necessarily indicative of fraud, Sterling's are in substantial part the result of a course of conduct that includes unlawful "unbundling" and "upcoding" billing practices, with reflexive ordering of special stains on nearly all specimens, even those not read by Sterling pathologists.

61. Special stain fraud is a well-known, revenue-driven unlawful laboratory scheme used by providers like Sterling who have ownership positions in Pathology labs.

62. Sterling's "self-referral" order rate for special stains was 100%-220%, compared to the approximate national standard of 5-10%. This resulted in systematically doubling and tripling Sterling's year-over-year earnings.

63. Sterling routinely upcoded by improperly self-ordering, and habitually adding "special stain" CPT codes to routine Pathology CPT codes without meeting any of the requirements for laboratory testing as outlined in Title 42, CFR 410.32(a).

64. In many instances, including for beneficiaries outlined in Section VII below, the special stain "Tests [were] not ordered by the physician who is treating the beneficiary," the reading pathologist, and were therefore "not reasonable and necessary." *Id.*

65. Special stains are required in uncommon instances and must be reviewed by a pathologist before being ordered. Reflex or pre-ordering special stains, as done by Defendants, indicates premeditated and deliberate medical billing fraud.

66. Defendants directed and required staff including administrative and clerical workers to pre-order and self-refer special stains for each specimen, resulting in double to triple revenues per specimen and circumventing the typical one specimen-one code rule in Pathology.

67. Defendants' annual revenues were substantially enhanced by their control over the number of inappropriate and self-ordered special stains at Sterling, instituting an unlawful business model of phantom requisitions, false Pathology reports, and duplicitous pre-ordering, among other schemes.

68. Reflex or pre-ordering special stains and/or ordering them for nearly every Pathology specimen (as done by *Sterling*), is all but a guarantee of premediated and deliberate medical billing fraud.

69. These institutional wide upcoding policies, knowingly devised by defendants, earned them sizable wealth while billing for Pathology slides, special stains, and other tests that were either not created or examined but billed, or not ordered by a treating physician and billed to the carriers.

70. The reading pathologist in most instances reads out the slide and report based on the H&E stain, but Sterling, Lekov and/or Yang then scrubbed the report and signed it themselves, always with an added-on special stain. As Such, Sterling in many cases as shown in Section VII below, has no legitimate physician order for performing special stain tests, no signatory, and no records conforming with CFR §410.32.

71. The rules require that the rendering pathologist must first review each routine H&E stain specimen before any special stain is ordered or billed. When performed in this

manner, special stains are billed separately and additionally. The use of special stains before the analysis of the routine H&E-stained specimen is medically unnecessary and therefore not reimbursable.

72. For every legitimate or actual surgical tissue specimen which Sterling received for routine Pathology, Sterling directed and required that the administrative staff or one of the pathologists pre-ordered and self-referred one or more special stains per tissue. Each improper special stain code then resulted in double to sometimes triple revenues per specimen in favor of Sterling. These unlawful billing practices are ongoing.

73. Sterling's fraudulent billing practices and special stain schemes have persisted for over a decade, and are continuing- allowing Defendants including Sterling executives, pathologists, and billing managers to accumulate significant wealth.

74. Defendants' disregard for medical necessity, correct billing, and reasonableness requirements contributed to a culture focused on maximizing revenues at the expense of lawful billing practices.

75. The improper self-referrals, upcoding, and ordering of special stains, along with the lack of compliance with regulations, indicate a deliberate and systematic effort by Sterling and its co-conspirators to defraud the healthcare system for financial gain.

76. The False Claims Act claim highlights Defendants' unlawful practices, emphasizing the need for accountability and proper oversight in the Pathology lab industry to prevent such fraudulent schemes from causing undue financial strain on the healthcare system.

77. By exposing Sterling's fraudulent billing practices, this action seeks to put an end to Defendants' systematic abuse of the system and ensure that other Pathology labs adhere to ethical and lawful practices for the benefit of patients, healthcare providers, and taxpayers.

78. Even worse, at least 15-25% of Sterling's COVID-19 testing revenues in 2021 and 2022 were procured through billing the state's insurance carriers– including Blue Cross,

Blue Shield, Aetna, Cigna, Humana, and United Healthcare– for *phantom testing*- testing which was never done nor results ever made available or reported to beneficiaries.

79. Sterling directly solicited beneficiaries to undergo its laboratory tests and agreed to not bill the beneficiaries for deductibles or co-pays in exchange for them undergoing any tests which Sterling ordered or billed. Sterling promised beneficiaries that the tests were fully covered and "free." Defendants also paid cash kickbacks to cappers and runners, including foreign nationals and immigrants contracted by a California *fabric company* and others to induce referrals to healthcare programs for laboratory testing.

80. Sterling mandates that its administrative staff reflex order special stains on all Pathology specimens for all beneficiaries, and that if any specimen is submitted for H&E Pathology, that a standing order for at least one special stain (and in some cases multiples) must be ordered per specimen received. In other instances, Sterling's administrative staff and transcriptionists are instructed to auto populate its reports with special stain verbiage, and cause charges to be billed to the carriers for special stains.

81. If a physician orders or a patient submits to one H&E stain service at Sterling, Sterling institutionally mandates that it must self-order and bill the carriers for at least one corresponding special stain code for each H&E code, thereby doubling and often tripling Sterling's earnings per specimen.

VI. DEFENDANTS' FRAUDULENT ACTS

A. Sterling Pathology

82. Defendant Changgao Yang, M.D. serves as Sterling's President, Chief Executive Officer (CEO), and "billing compliance officer" oversees contractor and employed pathologists[2].

83. Sterling pathologists and Defendants Yang and Lekov rank in the 95th-100th percentile in three categories for total payment per pathologist, highest number of patients,

[2] At relevant times, Sterling represented it employed six pathologists "Changgao Yang, M.D., PhD, Ellie Lekov, M.D., Kimberly Woodward, M.D., Paul F. Kirshman, M.D., William Ngoc Nguyen, M.D., and [Doctor 1] M.D."

and highest payments per patient statewide compared to the other approximately 1083 California pathologists.

84. Defendant Yang holds NPI 1366435638. Yang's excessive special stain order rates far exceed national standards of 5-10%. Specifically and by way of example, in calendar year (CY) 2017, YANG's production to one carrier was as follows: 5798 units of CPT 88305, and total 12,756 units of "special stains". Accordingly, YANG's "special stain" order and bill rate in CY 2017 was approximately 220%.

85. On analysis for 2017 CY, Defendant Yang billed Carrier 1 approximately $8,724,888 in that year alone, an average from 1.3 to 9.6 "special stains" per beneficiary as set forth below and in the table-

a) Yang billed 2776 units of special stain CPT 88312 on 1573 patients, thus an average order rate of 1.8 stains per patient;
b) An additional 6736 units of special stain CPT 88313 on 2248 patients, thus an average order rate of 2.99 stains per patient.
c) An additional 1098 units of special stain CPT 88341 on 271 patients, thus an average order rate of 4.1 stains per patient; and
d) A further 2146 units of special stain CPT 88344 on 224 patients, thus an average order rate of 9.6 stains per patient for this code.

CPT Codes	Number of Services	Number of Beneficiaries	Average Payment	Payments	**Special Stain Payments**
88305	5,798	2,385	$124.50	$296,933	
88312	2,776	1,573	$148.20	$233,120	$233,120
88313	6,736	2,248	$185.96	$418,032	$418,032
88341	1,098	271	$334.56	$90,667	$90,667
88342	528	416	$119.24	$49,603	$49,603
88344	2,146	224	$1531.60	$343,078	$343,078
Carrier 1 Payments					**$1,134,500**

86. Defendant Lekov holds NPI 1033266788. Lekov's excessive special stain order rates far exceed national standards of 5-10%. In CY 2017, Lekov's production

billed to one carrier was as follows: 2550 units of CPT 88305 for total specimens billed, and 4482 units of "special stains[3]". Accordingly, Dr. Lekov's "special stain" order and bill rate in CY 2017 was 172%, well above the national benchmark.

87. Defendants Sterling pathologists Yang and Lekov processed *fewer* specimens in 2013, but increased revenues through special stain upcoding, earning significantly more per patient and per-specimen than non-Sterling pathologists.

88. Despite CMS's national reduction of Pathology reimbursement by 30% effective January 1, 2013, Yang's upcoding scheme resulted in higher payments per patient in 2013, despite also having *fewer* specimens.

89. In contrast to non-Sterling pathologists operating within CMS's reduced Pathology allowances amounts, Sterling (Yang) billed and received on average 300%-500% more per patient during the same period.

90. In comparison to Yang's earnings of $537-$716 per patient as a result of upcoding with inappropriate special stain codes, an average non-Sterling pathologist in the same region earned only $75-105 per patient during the same time period.

B. Elite Medical Billing Corporation

91. Defendants Elite Medical Billing Corporation and Jenny Chang perform all of Sterling's coding, billing, collections, and appeals, in an ongoing relationship that facilitates Sterling's illicit practices. Elite and Chang processed Sterling's unlawful claims, securing a portion of the profits from fraudulent special stain upcoding and COVID-19 testing.

92. Granted direct access to Sterling's electronic medical records and billing data, Elite and Chang were able to review, audit, correct, appeal, and generate detailed reports on Sterling's billing practices. This included systematic upcoding, unbundling, and excessive use of special stain codes.

93. In 2022, Elite and Chang created and submitted approximately 200,000 new claims for COVID-19 testing on behalf of Sterling, thereby securing payments from the

[3] "Special Stains" CPT include codes 88312- 88313, and 88341- 88344.

state's carriers, and also under the CARES Act and HRSA COVID-19 Uninsured Program. To manage the surge in volume, Chang expanded Elite's operations by recruiting overseas billers.

94. Defendants Elite and Chang profited from Sterling's gross earnings based on an agreement that allotted them a portion of the gross collections. They supplied Sterling with the necessary coding, billing infrastructure, logistics, and staff, thus enabling Sterling's fraudulent billing practices.

95. Upon information and belief, communications, and directives between Sterling, Okuniewski, Yang, Lekov and Elite's ownership management under Chang required that all Pathology claims be scrubbed by Elite and Chang to add-on billing for at least one special stain code for each H&E code billed per specimen. This ensured no pathology claim was submitted without unbundling and upcoding.

96. Communications and directives between Sterling, Okuniewski, Yang, Lekov, and Elite's management under Chang indicated that all pathology claims should include at least one special stain code for each H&E code billed per specimen.

97. Despite their awareness of Sterling's fraudulent practices, Elite and Chang willingly participated in the fraud, processing false claims and upcoded entries, and transmitting fraudulent codes and claims for insurance payment. In return, they retained 5-6% of the gross collections from Sterling's unlawful billing.

98. Elite and Chang's close collaboration with Sterling enabled fraudulent billing, with both parties profiting from the increased revenues. From 2020 to 2023, they conspired to process false and fraudulent COVID-19 testing claims, which did not meet the regulations for those services. Sterling, remaining Elite's primary and most profitable client, led to a substantial volume and earnings surge due to the CARES Act.

99. As Chang explained it on or about April 4, 2023, Sterling remains her and Elite's "number 1" (and most profitable) client: "we were part of the CARES Act" so "our [2021 and 2022] volumes were through the roof."

100. For their pivotal role in facilitating Sterling's fraudulent billing, Elite and Chang received remuneration exceeding the scope of their "billing services". By merging their systems with Sterling's, they cemented their complicity in Sterling's fraudulent billing practices, receiving a percentage of the gross revenues and disproportionate "perks".

101. Elite and Chang's deep involvement in Sterling's operations allowed them a comprehensive insight into Sterling's patient database, pathology records, and medical requisitions. Their unrestricted, remote access into Sterling's complete data facilitated the perpetuation of fraudulent billing practices.

102. Despite being a medical billing company with an obligation to uphold lawful practices, Elite and Chang were complacent about Sterling's fraudulent addition of a special stain code to every H&E stain. Their remuneration was not in line with the standard "billing services" they purported to provide, indicating their complicity in Sterling's fraudulent practices.

103. By turning a blind eye to the fraudulent practices and facilitating the submission of false claims, Elite and Chang became key enablers in Sterling's unlawful operations. Their direct involvement and profiteering from Sterling's illicit gains underscore their active participation in the fraud.

104. All the fraudulent actions of Elite and Chang were carried out under the knowledge and directives of Sterling, Okuniewski, Yang, and Lekov. This high-level conspiracy was critical in maintaining Sterling's unlawful operations and resulted in significant financial damage to the state's carriers, and ultimately the taxpayers.

105. In summary, Elite and Chang were instrumental in facilitating and perpetuating Sterling's fraudulent practices. Their direct involvement, extensive access to Sterling's data, active participation in submitting false claims, and disproportionate remuneration highlight their complicity in Sterling's systematic defrauding of healthcare programs.

106. The relationship between Elite, Chang, and Sterling was not just a service provider-client relationship; it was a partnership in unlawful activities. The considerable

access Elite and Chang had to Sterling's data, their willingness to turn a blind eye to fraudulent practices, and their direct involvement in the fraudulent scheme.

107. Elite and Chang were not mere bystanders in Sterling's fraud against the state's carriers. They were active participants who benefited financially from their involvement. By processing, billing, and posting deposits for Sterling's unlawful claims, they directly profited from the fraud, collecting a percentage of the illicit gains.

108. Elite and Chang's involvement in this long running billing scheme was not incidental and went beyond mere negligence or ignorance; it was intentional and calculated to maximize their own financial gain at the expense of insurance carriers and taxpayers.

C. Defendants Executed A Widely Known Special Stain Over-Billing Scheme

109. Defendants' excessive profits originated from a carefully devised and intentional fraudulent course of action, encompassing unlawful upcoding and unbundling practices, as well as the employment of runners and cappers.

110. Sterling's lead executives, including CEO Yang and VP Okuniewski, devised, implemented, and enforced aggressive and illicit upcoding which focused on unlawful special stain codes, and they overlooked compliance issues and cultivated a profit-centric environment within the organization.

111. Sterling's illicit billing practices can be traced back to at least 2012, aligning with the arrival of VP and "marketing director" Okuniewski, who was instrumental in implementing Defendants' scheme to increase earnings despite decreasing patient numbers.

112. Sterling's fraudulent conduct was partially a reaction to CMS's (hence the state's carriers who largely follow CMS fee schedules) significant reductions in standard Pathology CPT code payments in 2009 and 2013, prompting Sterling to inappropriately upcode and take advantage of add-on special stain codes to manipulate its earnings.

D. Defendants Blatantly Violated Medical Billing Regulations.

113. Sterling, reliant on referring physicians and healthcare providers for submitting specimens for testing, encountered obstacles due to significant reductions in the CMS Pathology fee schedule. To counterbalance these financial challenges, Sterling

employed *self-referral* schemes, characterized by a substantial overutilization of special stains.

114. Defendants systematically engaged in reflexive and pre-ordering of numerous special stain codes for virtually every patient specimen submitted for Pathology services. They executed this without fulfilling the criteria of medical necessity, treating doctor's orders, and insurance requirements. Furthermore, Defendants reflex ordered special stains ***before*** pathologists had the opportunity to examine the H&E slide and neglected to accurately document the need for these deceptively billed special stains.

E. <u>Defendants' Knowingly Submitted False Claims.</u>

115. Defendant Okuniewski represented to Relator's principal that Sterling always has two pathologists review and read each slide but represented that they only bill the carriers for one doctor, not two.

116. Okuniewski admitted to Relator's principal and concurred that special stains should be ordered less than 10% of the time at sterling. On or about February 10, 2020 Okuniewski then misrepresented to Relator's principal that Sterling's special stain rate did not exceed 10%, which it did- in order to retain Relator's principal's account.

117. When confronted with Sterling's overutilization of special stains and billing for Patients 1 ,2, 3, and 4 in Section VII below, Okuniewski misrepresented that Sterling only ordered special stains in 10% of cases, and that special stains were not billed for each of these patients (which they were.)

118. Defendants' employees and staff were instructed to bill the carriers for unlawful special stains. Defendants' mandates included expressly using "generic" physician names (whom had no direct role with the services rendered) in on the Pathology report and outside Pathology consult requisition forms.

119. Defendants thus caused the submission of false claims to the carriers for special stains for each patient, and they knew that their practice of billing for special stains on every specimen or nearly every specimen was fraudulent.

120. Defendants told their employees to electronically transmit or mail false claims to the carriers for payment on countless Pathology and laboratory claims which Defendants knew violated the IFPA.

F. Defendants Obtained Payment for Tests by Falsely Certifying the Rendering Doctor's Name and/or Signature, and Medical Necessity.

121. The State's insurance carriers follow CMS payment guidelines and regulations which are set forth at 42 U.S.C. 1395(a)(I)(A). This provides… "no payment may be made … for any expenses incurred for items or services which ... are not reasonable and necessary." Medical necessity certificates must contain information required by the carrier to show that an item is reasonable and necessary.

122. Defendants submitted claims for payment relying on fraudulent medical necessity certificates, generic physician names, and fictitious ordering physicians. This large-scale fraud resulted in the defendants retaining millions of dollars in unearned payments.

123. Defendants directed managing agents and administrative staff to pre-sign blank medical necessity certificates, using these templates to create fraudulent certificates without the reading pathologist or treating physician's actual approval. In some instances, the medical transcription service was instructed to create false report templates, which automatically added a negative special stain result to all Sterling reports.

124. Defendants ordered and conducted tests without physicians' orders or medical necessity, defrauding the state's carriers on a massive scale and retaining tens of millions of dollars in unearned payments.

125. Defendants also received denials and record requests on some of their improper and duplicate claims. They presented false records for payments and deflected billing inquiries and complaints from confused beneficiaries questioning double Pathology charges.

126. To procure their fraud, Defendants instructed managing agents, including Lekov and administrative staff, to reflexively pre-sign blank certificates of medical necessity. Defendants used these "templates" to create fraudulent certificates of medical

necessity for their claims, without the treating physician or reading pathologist actually signing off on the specific special stain test underlying the claim.

127. Sterling, Yang, and Lekov's known practice of assigning "generic" doctor's names on Pathology reports and requisitions reflects a failure to comply with CMS rules which require accurate identification of the rendering provider by name and NPI.

128. Furthermore, Defendants ordered and conducted tests for which there were no physicians' orders or medical necessity. Defendants have perpetrated this fraud on a massive scale and have received many tens of millions of dollars in undeserved payments from the state's carriers.

Doctor 1

129. In Section VII below, Doctor 1 the reading pathologist, did not order the special stains added by Sterling for the beneficiaries. Sterling had no authority to order the special stains, as that authority belonged to Doctor 1.

130. Doctor 1 is an independent contractor who explains he reads on average 2-3 slides for Sterling per month. As a non-employed pathologist, Doctor 1 has not been to Sterling's premises since 2008 or 2009, when he visited once when he began his relationship with Sterling. Sterling ships out slides monthly to Doctor 1 who reads (interprets) Sterling's slides at his own company premises in another city and issues a formal Pathology report.

131. Sterling pays Doctor 1 per slide on an end-of-month invoicing. Sterling suppresses Doctor 1's Pathology report, issues its own report, and adds and bills a special stain code and service which was neither ordered by Doctor 1 nor performed or read out by him.

132. Sterling does not disclose that it bills for special stains on the slides read by Doctor 1 which neither required a special stain for the final diagnosis, nor did Doctor 1 order a special stain.

133. Sterling's practice of suppressing Doctor 1's Pathology report, issuing its own report, and adding special stain codes and services without Doctor 1's authorization or medical necessity constitutes fraud under the IFPA.

134. Doctor 1 neither requested the special stain services which were billed by Sterling, Yang, and Lekov, nor authorized the special stains, nor billed the carriers for reading these special stains. Doctor 1's billing records reflect his annual special stain order and bill rate year-over-year is approximately 2.1%, at least one hundredfold less than Defendant Yang's special stain order rate.

135. Doctor 1, the reading pathologist on Sterling's reports, never ordered the special stains, and Sterling added the special stain code after Doctor 1 read the slides and had rendered his final diagnosis. Not only was there no medical necessity for the special stain Sterling billed, but there was also an absence of a treating physician order for it. Sterling did not have any authority to even order the special stains because Doctor 1 held that authority as the reading pathologist.

Doctor 2

136. Similarly, Doctor 2, the reading pathologist, did not authorize the special stains added by Sterling for patients, including Patient 5 discussed in Section VII below. Sterling had no authority to order the FIVE special stains for Patient 5; that authority lay exclusively with Doctor 2, the rendering and reading pathologist. Insurance carriers do not reimburse for tests unless they are ordered by the treating physician or the rendering provider. As neither the patient's treating doctor nor Doctor 2 ordered these special stains and given that these were reflexive and cloned special stain orders directed by business imperatives from Defendants Sterling, Yang, Lekov, Okuniewski., Elite, and Chang, each of these FIVE special stains constitutes a separate false claim under the IFPA.

G. Defendants Habitually Upcoded and Unbundled Special Stain Test Claims for Unjust Enrichment

137. Sterling upcoded, unbundled, billed, and received and retained payments from the state's carriers for test claims which did not conform to NCCI, violated the rules for special stains, were not ordered by the treating physician, were medically unnecessary, were in some instances incompatible special stain code and diagnosis combinations, and

failed to adhere to billing mandates for countless beneficiaries including Patients 1,2, 3, 4, and 5 as outlined in Section VII below.

138. Defendants conspired to violate the IFPA by causing the submission of false or fraudulent claims; conspired to make and use, or cause to be made or used, false records material to false or fraudulent claims; and once put on notice of the unlawful billing, conspired to not disclose, or return the resulting overpayments to the carriers.

139. By consistently and knowingly adding special stains without medical necessity or physician orders, Defendants Sterling, Yang, and Lekov have defrauded the state's carriers, collecting tens of millions of dollars in undeserved payments.

140. Defendants' fraudulent practices have not only caused financial harm to the state's carriers but have also jeopardized the health and wellbeing of patients by providing them with potentially unnecessary and misleading diagnostic information.

141. The fraudulent actions of Defendants Sterling, Yang, Lekov, and their managing agents, including Okuniewski, have violated the IFPA and caused substantial harm to the state's carriers, as well as to their beneficiaries.

142. In light of the substantial fraud perpetrated by Defendants and the harm caused, Defendants must be held fully accountable for their unlawful actions and to recover the ill-gotten gains obtained through their fraudulent practices.

143. The practices complained of herein are *continuing*, resulting in the submission of additional false or fraudulent claims.

H. Defendants Affirmatively Modified Their Upcoding And Unbundling Practices To Evade Detection.

144. On or about January 1, 2020, Defendants Sterling, Yang, Lekov, Okuniewski, and Does 1-10 modified their companywide upcoding and unbundling mandates and policies to add certain verbiage to their Pathology reports as follows "Initial H&E reviewed. Special stains are performed and reviewed when indicated, with appropriate negative and positive controls." Although sterling did not change its company mandate to unlawfully upcode each

specimen with a minimum of one special stain, it added the language intended to evade repayment demands.

145. Sterling's described policy change is evident when analyzing Sterling's 2017 Pathology reports compared to its 2020 reports. However, regardless of Sterling's amended documentation, every patient's specimen was reflexively required to be pre-ordered and billed for a special stain, regardless of lack of medical necessity or the lack of an authorized physician order for the special stain. Hence, Sterling continues to unlawfully and with knowing intent upcode and bundle Pathology specimens with at least one special stain code per specimen.

I. Defendants Billed For COVID-19 Testing Which Was Never Performed.

146. Sterling claimed a capacity for performing "33,000" COVID tests per week, all compensated by the state's carriers, or in part through the CARES Act and the HRSA COVID-19 Uninsured Program. The carriers require that for the laboratory service to be deemed reimbursable, testing results must be made available to the treating provider, or in some cases directly to the patient.

147. During 2021 and 2022, Sterling collected more COVID-19 samples than they could test due to their illicit marketing and recruitment practices. Despite lacking the resources required to timely or adequately process these specimens, Sterling failed to halt sample collection. Consequently, Sterling was unable to process numerous specimens and failed to provide results, despite billing the carriers for all collected samples, regardless of whether they were tested.

J. Defendants Engaged In Pass-Through Billing.

148. Sterling utilized pass-through billing, contracting with external laboratories and pathology corporations to perform medical testing services, yet billed the state's carriers as if the tests were conducted in-house. This misleading practice allowed Sterling to charge inflated prices for the tests, thereby profiting from the unwarranted markup.

149. Defendants unethically billed insurance carriers globally for services performed by external labs, including *Neogenomics Laboratories Inc.,* at marked-up prices, in violation of regulations.

150. The state's carriers use all codes and modifiers as set forth by the AMA and CMS. CMS mandates that any service attached to a line-item CPT 90 modifier must disclose the provider's information. Defendants neglected to adhere to these regulations in their billing practices, including failing to correctly identify the reading pathologist's NPI and neglecting to attach a modifier 90 on healthcare lab claims. Defendants inappropriately used external labs and pathologists without appropriate disclosure or billing adjustments.

151. From at least 2008, Defendants systematically contracted with independent pathologists (such as Doctor 1 and Doctor 2), physically sending glass slides to pathologists located away from Sterling's premises for pathology report generation.

152. Despite the fact that contractors did not read the slides at Sterling's premises in Seal Beach, Sterling failed to accurately reflect the place of service on its claims to the carriers. Sterling misrepresented the services rendered by omitting correct modifiers and other claims information.

153. Sterling also neglected to comply with Correct Coding Initiatives (CCI), which mandate the addition of a -90 modifier to identify services performed by a party other than the reporting physician.

154. Further, Sterling concealed the external pathologists' report from the medical record but used the external pathologist's name on Sterling's final Pathology report, falsely implying that Sterling provided the services.

155. Sterling subsequently billed the carriers under their own doctors' names for services they did not provide. Sterling's alleged "ordering doctor" for most of its special stains was illusory, as the "generic" named pathologist on some reports never read the Pathology slide upon which Sterling billed for its special stain.

156. By misrepresenting the true provider of the services and neglecting to properly apply required billing modifiers, Sterling violated applicable laws and regulations, including the IFPA, which aim to prevent fraud and abuse in the healthcare system.

VII. DEFENDANTS' EXEMPLAR FALSE HEALTHCARE CLAIMS

157. Defendants submitted false claims and received and retained payments for upcoded and unbundled special stain codes from the state's carriers. The following examples detail Defendants' fraudulent billing practices for five patients, involving unnecessary special stains, upcoding, and unbundling charges:

A. Patient 1 (E.M., age 76)

158. Defendants Sterling, Elite, Chang, and Dr. Lekov billed unnecessary special stain services for Patient 1, which were read by an outside contracted dermatopathologist, Doctor 1. No medical necessity or treating physician's request was present for the special stain. The special stain was marked as negative "(ct/mw)." The claim was submitted on February 6, 2020, and payment was obtained, hence a false claim.

159. Sterling's report reflects the actual service was performed (read out) by an outside (contracted) pathologist Doctor 1, however Dr. Lekov signed and issued the final Pathology report which ADDED a special stain service, which resulted in improper unbundling and upcoding, including CPT code 88305 for a standard H&E stain and an additional CPT code 88312 for a special stain.

160. There was no medical necessity for the special stain as Doctor 1 made his final diagnosis based on the routine H&E stain. There was also no order or request by Doctor 1 for a special stain or any comment requiring further testing.

161. Patient 1's treating physician did not request or order the unnecessary special stain service and charge, which Sterling and Lekov reflex added solely pursuant to Defendants' billing mandates.

A. Patient 2 (J.J., age 68)

162. Similarly, Defendants and Dr. Lekov billed unnecessary special stain services for Patient 2, which were read by dermatopathologist Doctor 1. No medical necessity or treating physician's request was present for the special stain. The special stain was marked as negative "(ct/mw)." The Pathology report shows that the additional service was unnecessary and not medically justified. The special stain claim was submitted on February 6, 2020, and payment was obtained, hence a false claim.

B. Patient 3 (W.M., age 89)

163. Likewise, Defendants and Dr. Lekov upcoded and billed unnecessary special stain services for Patient 3, which were read by dermatopathologist Doctor 1. No medical necessity or treating physician's request was present for the special stain. The Pathology report reflects the special stain was negative and marked as "(ct/mw)." The claim was submitted on February 6, 2020, and payment was obtained, hence a false claim.

C. Patient 4 (M.B., age 73)

164. Defendants and Dr. Lekov upcoded and billed unnecessary special stains for Patient 4, which were read by Doctor 1. They submitted two false claims for special stains. Both special stains were marked as negative, with no medical necessity or treating physician's request for either stain. The special stain claims were submitted in 2020, and payments were obtained, hence two false claims.

D. Patient 5 (S.B., age 61)

165. Defendants and Dr. Yang upcoded and billed the state's carrier for five false and unnecessary special stain services for Patient 5, which were read by Doctor 2. All five special stains were marked as negative "(nh/es)" with no medical necessity or treating physician's request. Sterling could not produce any special stain slides for this patient, as they likely never existed. Five special stain claims were submitted for payment on April 6, 2017, and payment was obtained for this claim- hence five false claims.

166. There was no indication of medical necessity for the reflex special stains because Doctor 2 made her final diagnosis on the routine H&E stain.

167. There was also no order or request by the reading pathologist Doctor 2 for a special stain on either of these FIVE specimens, or any comment in her reading which required a special stain on any of the FIVE specimens. Further, there was no clinical information or request by Patient 5's treating provider that either expressly requested or ordered the special stains.

168. Neither Sterling nor its representatives could produce any of the "special stain" slides for Patient 5 despite multiple demands for them to produce the slides, raising questions about their existence. This lack of evidence suggests that the slides might have never existed in the first place, further implicating Sterling and its representatives in fraudulent billing practices.

VIII. LEGAL FRAMEWORK

A. Violations of the California Insurance Fraud Prevention Act (IFPA)

169. This claim for violations of the California Insurance Frauds Prevention Act, Cal. Ins. Code § 1871, et seq., is brought by Relator in the name of the State of California, pursuant to Ins. Code § 1871.7(e). Relator is an "original source" of the information on which this claim is based, as that term is defined in Ins. Code § 1871.7(h)(2)(B).

170. In enacting the IFPA, the Legislature found and declared that:

> The business of insurance involves many transactions that have the potential for abuse and illegal activities. There are numerous law enforcement agencies on the state and local levels charged with the responsibility for investigating and prosecuting fraudulent activity. This chapter is intended to permit the full utilization of the expertise of the commissioner and the department so that they may more effectively investigate and discover insurance frauds, halt fraudulent activities, and assist and receive assistance from federal, state, local, and administrative law enforcement agencies in the prosecution of persons who are parties in insurance frauds. Cal. Ins. Code § 1871(a).

171. With regard to healthcare fraud in particular, the Legislature found and declared that:

Health insurance fraud is a particular problem for health insurance policyholders. Although there are no precise figures, it is believed that fraudulent activities account for billions of dollars annually in added health care costs nationally. Health care fraud causes losses in premium dollars and increases health care costs unnecessarily. Cal. Ins. Code § 1871(h).

172. To redress and disincentivize such fraud, in pertinent part, the IFPA provides that:

> Every person who violates any provision of . . . Section . . . 550 . . . of the Penal Code shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000), plus an assessment of not more than three times the amount of each claim for compensation . . . pursuant to a contract of insurance. . . . The penalty prescribed in this paragraph shall be assessed for each fraudulent claim presented to an insurance company by a defendant and not for each violation. Cal. Ins. Code § 1871.7(b).

IX. CLAIMS FOR RELIEF

A. FIRST CLAIM

VIOLATION OF THE CALIFORNIA INSURANCE FRAUDS PREVENTION ACT

By Plaintiff The State of California Against All Defendants and Does 1-10

173. Plaintiff repeats and re-alleges all the preceding paragraphs of the Complaint inclusive, as if fully set forth herein.

174. By falsely certifying the accuracy, completeness, and compliance of their reimbursement claims within the State's laws and IFPA, regulations, and instructions for payment, Defendants knowingly submitted false or fraudulent claims. This action is in violation of Cal Ins. Code 1871.

175. Due to Defendants' false claims, the State's carriers disbursed funds that would not have been paid if the falsity were known. Each false claim constitutes a separate violation of the IFPA.

176. During the statutory period, Defendants violated the IFPA in several ways. They submitted claims to the State's carriers for tests that did not meet coverage requirements and misrepresented them as meeting such requirements. They claimed tests were medically necessary when they were not and claimed that tests were not illegally induced through offers of remuneration.

177. Defendants knowingly submitted upcoded and unbundled claims for Pathology special stains under CPT codes 88312-88313, 88341-88344, among other codes, for numerous beneficiaries under the State's insurance . This includes false special stain claims for Patient 1, 2, 3, 4 and 5 as outlined in Section VII. Defendants knew these tests were not covered by insurance carriers, yet they upcoded and unbundled claims for unjust enrichment.

178. Defendants acted with intent to defraud, and they had knowledge of the information or acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Defendants acted **with intent** in the following ways:

(i) Defendants had actual knowledge of their billing practices. They were directly involved in using external labs and pathologists without proper disclosure and billing adjustments, and they deliberately and improperly billed the carriers globally for services performed by external labs at marked-up prices (pass-through billing.)

(ii) They acted in deliberate ignorance of the truth by claiming that two pathologists read each slide while billing for only one reading. They contracted with independent pathologists, sent slides offsite for reading, and failed to correctly reflect the true rendering provider on claims.

(iii) Defendants acted in reckless disregard of the truth when they named a generic purported "ordering doctor" for most special stains, knowing that some of these named pathologists never read the slides for which they were billed.

(iv) Defendant Okuniewski represented to the Relator's principal that Sterling *always has two pathologists review and read each slide "at no extra charge,"* despite evidence demonstrating otherwise. He also misrepresented that Sterling's special stain rate was "under 10%", and conformed to national standards, despite mountains of evidence showing Sterling's special stain order rate far exceeded 10% (was 100%-220%.) These misrepresentations demonstrate actual knowledge of the information related to Defendants' fraudulent billing practices.

(v) Sterling routinely added a special stain result and bill to each report read by outside pathologists who never used or ordered such stains, further demonstrating deliberate ignorance of the truth or falsity of the information when billing the State's for these services.

(vi) The State's carriers required that outside services not be marked up when the referring lab bills for technical services performed by the reference lab. Yet, Defendants knowingly disregarded this requirement by billing the carriers globally for lab services at marked-up prices.

(vii) Defendants failed to comply with the State carriers' regulations that require them to correctly identify and bill using the reading pathologist's NPI and attach modifier 90 on their healthcare lab claims performed by reference laboratories. This shows a reckless disregard for the truth or falsity of the information in their billing practices.

(viii) Elite Medical Billing Corporation, managed by Jenny Chang, knowingly and actively participated in the fraudulent billing practices by submitting false claims to the State's carriers the States on behalf of Sterling. Elite's involvement in submitting these false claims shows actual knowledge of the fraudulent information.

(ix) Chang, as Elite's principal and manager, was responsible for overseeing the billing practices and ensuring compliance with insurance regulations. Her position within the company indicates that she either had actual knowledge of the false information or acted in deliberate ignorance of the truth or falsity of the information related to the fraudulent billing practices.

(x) Elite and Chang facilitated the submission of false claims for unnecessary laboratory tests, including special stain Pathology tissue services and COVID-19 testing, by engaging in upcoding, unbundling, and using contracted cappers, runners, and kickbacks to obtain patients' insurance information for unearned COVID-19 insurance payments. This demonstrates a reckless disregard for the truth or falsity of the information in their billing practices.

179. In summary, Defendants knowingly submitted false claims to the State's carriers, acted in deliberate ignorance and reckless disregard of the truth, and misrepresented their compliance with healthcare billing laws, regulations, and instructions for payment. These actions led to disbursements that would not have been made had the falsity been known, causing significant damages. Each of these actions violates the False Claims Act.

180. Due to the false claims knowingly submitted by Defendants, the State and its insurance carriers suffered substantial damages, the final amount to be determined at trial.

181. Defendants knowingly submitted or caused to be presented to insurance carriers false or fraudulent claims for payment or approval for payment, including but not limited to the exemplar false claims identified in Section VII of this Complaint. Defendants' conduct was a substantial factor in causing the false claims to be presented. Defendants provided their knowing misrepresentations for the purpose of obtaining insurance payments to which they knew or should have known they were not entitled under proper payment rules for laboratory and special stain claims. This knowledge was demonstrated as follows:

(i) Defendants had actual knowledge of their billing practices, as they were directly involved in using external labs and pathologists without proper disclosure and billing adjustments. They also deliberately and improperly billed the carriers globally for services performed by external labs at marked-up prices (pass-through billing).

(ii) Defendants acted in deliberate ignorance of the truth or falsity of the information by claiming that two pathologists read each slide while billing for only one reading. They contracted with independent pathologists, sent slides offsite for reading, and failed to correctly reflect the true rendering provider on claims, as was otherwise required.

(iii) Defendants acted in reckless disregard of the truth or falsity of the information when they named a generic purported "ordering doctor" for most special stains, knowing that some of these named pathologists never rendered services or read the slides they billed for.

(iv) Defendants failed to comply with insurance regulations that require them to correctly identify and bill using the reading pathologist's NPI and attach modifier 90 on their healthcare lab claims performed by reference laboratories. This shows a reckless disregard for the truth or falsity of the information in their billing practices.

182. Defendants' misrepresentations had a natural tendency to influence or were capable of influencing the insurance carriers' decisions to remit payments on the false claims at issue in this action, and to make remittances to Defendants on claims which violated the IFPA, including but not limited to the claims identified in Section VII.

183. By the same acts, Defendants knowingly made false records or statements to get fraudulent claims paid by the state's insurance carriers.

184. Defendants' misleading records or statements influenced the insurance carriers' payment decisions for false claims.

185. Defendants submitted non-compliant and medically unnecessary tests including those for special stain pathology codes and COVID-19 testing to insurance carriers, using false documents to present them as compliant.

186. For each claim, including those for patients in Section VII of this Complaint, Defendants knowingly assisted in or conspired to present false or misleading information in support of a claim for payment, violating IFPA.

187. As a result of Defendants' actions, the State claims damages in excess of the jurisdictional limits of this court the specific amount to be determined at trial.

B. SECOND CLAIM

VIOLATION OF THE IFPA- ILLICIT MARKETING AND USE OF RUNNERS AND CAPPERS TO PROCURE COVID-19 TESTING

By Plaintiff Against All Defendants and Does 1-10

188. Plaintiff repeats and re-alleges all preceding paragraphs of the Complaint inclusive, as if fully set forth herein.

189. Defendants knowingly and willfully violated Cal. Insurance Code Section 1871.7(a) which prohibits the knowing use of "runners, cappers, steerers, or other persons to procure clients or patients to perform or obtain services and benefits... under a contract of insurance."

190. The IFPA codified by section 1871.7 makes it unlawful to offer or pay remuneration, including kickbacks, to induce referrals for laboratory testing pursuant to an insurance contract.

191. As this country struggled to cope with a devastating pandemic, Defendants also conspired further to swindle insurance providers out of millions of dollars. They engaged in illicit COVID-19 test billing using unlawful contracted cappers, runners, and kickbacks to obtain patients' insurance information and driver's licenses for unearned payments under the COVID emergency payments including those provided under the

COVID-19 CARES Act and the "HRSA COVID-19 Uninsured Program." They exploited the healthcare system when it was at its most vulnerable, indirectly raising healthcare costs for everyday Americans.

192. In 2020, Sterling initiated a fraudulent scheme involving COVID-19 test overbilling. This scheme resulted in illicitly obtained revenues exceeding tens of millions of dollars.

193. Defendants Sterling, Elite, and Chang capitalized on the COVID-19 pandemic, generating significant revenue through illegal marketing practices, including the payment of over $1.2 million in kickbacks to patient recruiters conditioned on steering patients and securing "clean claims" paid under the COVID-19 emergency including the CARES Act.

194. From mid-2020 through February 2023, Sterling contracted with a large number of third-party independent runners, cappers, and agents to solicit, procure, and refer specimens for Sterling's COVID-19 scheme, including Company 1, a *fabric company* to act as Sterling's "Agent" to "provide nasal specimen collection services for COVID testing." Sterling paid these unqualified agents for performance and expressly conditioned its payments on the contractual obligation that "*the specimens were properly documented by Agent, Sterling submitted billing to insurance payers and to the HRSA COVID-19 Uninsured Program and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) for specimen services*."

195. Defendants entered into numerous illicit referral agreements, several labeled as "Lab Services Agreements" (LSA). These agreements, both written and verbal, involved third-party patient recruiters who agreed to steer patients to Sterling and provide patient demographic information, including copies of insurance cards and driver's licenses, in exchange for payments ranging from $18 to $39 for each referral leading to a "clean claim" submitted to the insurance carriers. Notably, Defendants misrepresented the fair market value for specimen collection services in their contracts, stating a range of $18-$21, which aligns more closely with industry standards. However, in practice, they incurred or paid $35- $39 per specimen, a sum significantly above fair market value, thus indicating their

intent to incentivize referrals rather than simply pay for services rendered. This discrepancy further substantiates the allegation that these payments were indeed kickbacks intended to induce referrals, rather than legitimate compensation for services.

196. Defendants knowingly and willfully paid more than fair market value for COVID-19 patient demographic and driver's license and/or specimen collection. They actually incurred and paid $35-$39 per billable specimen, but concealed this amount by writing in their LSA contracts that they would pay $18-$21 per specimen. Further, Defendants conspired with individual 1 and Company 1 and Individual 2 and Company 2 to conceal the kickback fees they paid. This is a violation of the IFPA, which prohibits knowingly and willfully submitting false claims to insurance carriers.

197. These illicit practices induced even healthy individuals to undergo unnecessary tests. The costs of these unnecessary tests were then fraudulently passed on to insurance carriers, including those emergency funds allocated through the COVID-19 CARES Act.

198. Defendants' actions constitute a violation of the IFPA as they offered, solicited, and paid kickbacks to induce referrals for laboratory testing from insurance carriers, leading to an increase in unnecessary tests and false claims, thereby causing substantial financial damage to the State.

199. On information and belief, Defendants further exploited the patient information obtained through these illicit practices by fraudulently billing for double billing, and billing additional tests and procedures not supported by diagnosis codes or eligible for reimbursement, as well as multiple and repeat claims for the same services on the same patients- tests which were never performed.

Discounts and "Perks"

200. Defendants engaged in unlawful practices by offering and providing prohibited forms of remuneration in the form of discounts and "perks." Specifically, Defendants routinely reduced or waived coinsurance and deductible amounts for patients, while billing and collecting from the State's insurance carriers in full.

201. Defendants did not report these reductions or waivers to the insurance carriers, and continued to bill the carriers at the full rate for tests.

202. In order to induce patients to submit to their tests, Defendants, including Elite and Chang, routinely offered to reduce or waive beneficiaries' co-pays and deductibles.

203. Defendants used these reductions and waivers to encourage patients to undergo tests and to discourage them from filing complaints or reporting Sterling's upcoding to the insurance carriers and the government.

204. Furthermore, Defendants routinely offered "perks" to community physicians and providers, such as free meals, sponsorships, uncompensated services, and other remuneration, in exchange for access and to promote overutilization of Sterling's lab services and self-ordering of special stains tests for their patients.

205. As a direct result of these unlawful schemes, Defendants induced providers to order tests and patients to undergo tests that they would not have otherwise ordered or submitted to, and further discouraged them from reporting Defendants to the carriers and the government.

Company 1

206. On or around September 16, 2021, Defendants Sterling, Yang, and Okuniewski conspired with Company 1, pursuant to a "Laboratory Services Agreement" (LSA), to unlawfully collect and exploit insurance and identification details for fraudulent insurance carrier billing, largely targeting immigrant communities in Los Angeles and surrounding areas.

207. Defendants directed Company 1 to obtain as many insurance cards and drivers' licenses as possible, with the aim of maximizing Sterling's fraudulent billings, irrespective of whether the billed tests were performed.

208. Sterling and Okuniewski, intending to defraud the carriers, instructed Company 1 to collect insurance and identification details for fraudulent COVID-19 test billing, compensating Company 1 on a per claim basis, ranging from $18 to $39.

209. The LSA obligated Company 1 to provide Sterling with personal demographic information and copies of primary insurance details, as required for "clean claim" billing.

210. For each patient recruited by Company 1, Sterling incurred fees ranging from $18 to $21. Despite the explicit terms of the written LSA, Sterling verbally agreed to reimburse Company 1 at a higher rate, while simultaneously professing a desire to avoid violations of Stark Law and the federal Anti-Kickback Law.

211. On or around May 18, 2022, Company 1 and Sterling executed a "Services Payment Agreement," in which Sterling committed to an additional payment of $171,752.00 for Company 1's services.

Company 2

212. Similarly, on or around January 15, 2021, Defendants Sterling, Yang, and Okuniewski conspired with Individual 2 and Company 2, to unlawfully collect and exploit identification and insurance details for fraudulent insurance billing, predominantly targeting immigrant communities in California.

213. Between January and December 2021, Company 2 collected over 13,000 patient demographics and billing information for Sterling's fraudulent testing scheme. Each fraudulent "clean claim" incurred fees of $39 to Company 2, with no written agreement due to the Defendants' concerns about violating the Anti-Kickback Statute (AKS).

214. Sterling remunerated Individual 2 or Company 2 with $276,235.71 for their services in recruiting patients and facilitating fraudulent laboratory billing, thus inducing referrals for insurance carrier covered services.

Defendants Solicited and Induced Orders for Lab Services

215. From in or around May 2020 and continuing through June2023 in the jurisdiction of this Court, Defendants and Does 1-10 knowingly and willfully conspired and agreed with third parties including Company 1, Company 2, Individual 1, Individual 2, and others to commit offenses as follows:

a) By soliciting and receiving any remuneration, specifically, kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, in return for referring an individual to a person for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole and in part by an insurance carrier; and

b) By offering and paying any remuneration, specifically, kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, *to* any person to induce such person to refer an individual to a person for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole and in part by an insurance contract .

216. It was the **goal** of the conspiracy for Defendants Yang, Okuniewski, Lekov, Sterling, and their co-conspirators to unlawfully enrich themselves by, among other things, soliciting, receiving, offering, and paying kickbacks and bribes in return for recruiting and referring beneficiaries to Sterling for diagnostic testing, including COVID-19 testing.

217. The **manner and means** by which Defendants Yang, Okuniewski, Lekov, Sterling and their co-conspirators sought to accomplish the goal of the conspiracy included, among other things, the following:

a) Defendants Yang, Okuniewski, and Sterling agreed to and did offer and pay illegal kickbacks and bribes to Company 1 and/or Individual 1 and Company 2 and/or Individual 2 in exchange for signed requisition forms and/or specimens that were sent to Sterling and Elite for the purpose of performing tests that were billed to insurance carriers, and otherwise the government under the COVID-19 CARES Act.

b) Defendants Yang, Okuniewski, and Sterling agreed to and did pay Company 1 and/or Individual 1 and Company 2 and/or Individual 2 a percentage of the insurance reimbursement for specimens and signed requisition forms that Company 1 and Company 2 referred to Sterling.

c) Individual 1 and Individual 2 worked together to generate referrals for COVID-19 testing targeting immigrant communities in California. Specifically, Individual 1, and Individual 2 in large part dispatched Chinese speaking agents to set up booths to persuade immigrant insurance beneficiaries to submit to laboratory testing, including COVID-19 testing, by providing their driver's license and insurance information. Defendants and Does 1-10 signed the electronic claims and testing requisition forms generated by Individual 1 and Individual 2 through their community dispatchers and submitted these to the State's carriers and the government for payment.

d) To disguise the scheme, Defendants Yang, Okuniewski, Sterling, Elite, Chang, Individual 1, and Individual 2 created sham documentation, including "LSA" and ledgers, to conceal and disguise the illegal kickbacks and bribes paid by Defendants in exchange for signed requisition forms and specimen referrals.

218. In **furtherance of the conspiracy** and to accomplish their goals, Defendants their co-conspirators committed, and caused to be committed, the following acts in California and elsewhere:

a) From on or about January 6, 2022 to January 4, 2023, Defendants Yang, Okuniewski, and Sterling wrote multiple checks in amounts totaling $276,235.71 payable to Company 2 and/or Individual 2 and drawn on the Sterling bank account, in exchange for specimens and requisitions referred by Company 2.

b) On or about November 8, 2022, Defendants Yang, Okuniewski, and Sterling wrote checks in amounts totaling approximate $129,000, payable to Company 1 and/or Individual 1, and drawn on the Sterling bank account, in exchange for specimens and requisition forms referred by Company 1 and Individual 1.

219. Sterling's illicit marketing scheme to recruit patients (specimens) for largely unnecessary laboratory tests between late 2020 to early 2023 was wildly profitable and successful. At the relevant times, Sterling collected roughly $100-$200 per specimen from the carriers and the government, while *incurring* fees to cappers of $18-$39 per recruited

and procured patient and sharing approximately 5-6% commission on its gross collections to Elite and Chang.

220. Defendants Yang, Okuniewski, and Sterling incurred or paid Individual 1 and/or Company 1 and Individual 2 and/or Company 2 approximately $550,000 in exchange for diagnostic testing referrals, including COVID-19 testing and other laboratory referrals, that they caused to be referred to Sterling.

221. Furthermore, Defendants offered and paid cash or cash equivalents to runners, cappers, and health care providers to induce orders for their tests, or to allow Defendants access to independent third-party information collectors to bill for eligible insurance beneficiaries.

222. Sterling represented a capacity for performing "33,000" COVID tests per week, all of which were compensated either by the State's insurance carriers, or the government through the CARES Act and the HRSA COVID-19 Uninsured Program.

C. THIRD CLAIM

MAKING OR USING FALSE RECORD MATERIAL TO CAUSE OBLIGATION TO PAY

By Plaintiff Against All Defendants and Does 1-10

223. Plaintiff repeats and reincorporates the allegations of all previous and subsequent paragraphs as if set forth in full at this point.

224. Throughout the statutory period, Defendants made and used or caused to be made or used false records or statements material to an obligation to pay or transmit money to the State's insurance carriers, or knowingly concealed, avoided, or decreased an obligation to pay or transmit money to the carriers.

225. Said false records or statements were made with actual knowledge of their falsity, or with reckless disregard or deliberate ignorance of whether or not they were false.

226. Defendants violated the IFPA from at least January 9, 2013 to the present by engaging in the fraudulent and illegal practices described herein.

227. Defendants furthermore violated Cal. Ins. Code 1871 and knowingly caused hundreds of thousands of false claims to be made, used, and presented to the State's carriers from at least January 9, 2013 to the present by its violation of State and federal laws as described herein.

228. Specifically, Defendants knowingly created or utilized false documentation asserting that their tests complied with coverage requirements when submitting claims for payment to the State's insurance carriers.

229. Defendants used these false records and statements to secure unlawful payments for numerous beneficiaries, including but not limited to Patients 1,2,3,4, and 5 as outlined in Section VII.

230. Compliance with applicable statutes including commercial carriers, Medicare, Medi-Cal, and the various other federal and state laws cited herein was implied, and also was an express condition of payment of healthcare claims submitted in the State of California.

231. Had the State known that Defendants were violating the federal and state laws cited herein, it would not have allowed to be paid the claims submitted by health care providers and third-party payers in connection with Sterling's fraudulent and illegal practices.

232. Defendants and each of them conspired with one another to get false and fraudulent healthcare claims allowed and paid under the laws of the State.

233. Defendants acted in a concerted fashion to defraud the commercial payors in the State and acted with others in keeping the facts necessary to investigate the fraud and the damages caused by the fraud away from the State of California.

234. Sterling executives with knowledge of the fraudulent billing activities alleged herein include Defendants Yang, Okuniewski, and Lekov, who knew of and directed those under them to present false records material to obligation to pay and instructed those under them to conceal Defendants' demonstrated schemes and institution's billing noncompliance.

235. The State, by and through, the administration of its insurance programs and its carriers, unaware of Sterling's fraudulent and illegal practices, was damaged by carriers' payment of the claims submitted by health care providers.

236. As a result of the actions of Sterling and named Defendants, the State and its people have been severely damaged.

D. FOURTH CLAIM

CONSPIRACY TO VIOLATE THE IFPA

By Plaintiff Against All Defendants and Does 1-10

237. Plaintiff repeats and re-alleges all preceding paragraphs of the Complaint inclusive, as if fully set forth herein.

238. As set forth above, Defendants and Does 1-10's directors, managing agents, and other employees conspired with each other and unnamed parties to seek and obtain payments by submitting claims based on fraudulent representations and records.

239. Yang, Okuniewski, and Sterling conspired to boost Sterling's revenues through upcoding and unbundling schemes. They charged one or more special stain codes for every specimen processed, intending to double or triple Sterling's per specimen revenues.

240. Drs. Yang and Lekov agreed to employ "generic" physician names on Pathology reports and to self-order and bill unnecessary special stains codes for each specimen processed at Sterling, generating false and fraudulent Pathology reports to defraud the insurance carriers.

241. Yang and Okuniewski, agreed to execute institutional wide upcoding policies whereby special stains were pre-ordered for all or nearly all Pathology specimens submitted to Sterling. As an overt act in furtherance of their conspiracy to defraud health carriers, the

conspirators developed reflex algorithms whereby specimens would have "special stains" attached, thereby all conspirators stood to substantially benefit from their unlawful acts.

242. Yang, Okuniewski, and Lekov then agreed to implement institutional wide policies whereby special stains were ordered for all or nearly all Pathology specimens submitted to Sterling. Thus, when Yang was unavailable or out of town, Lekov would sign or authorize the transcriptionist to stamp her signature on fraudulent Pathology reports with phantom "special stains" which were typically not even performed.

243. Yang, Okuniewski, and Lekov also entered into an agreement with their fellow in training Dr. Kimberly Woodward to also assist Sterling and agreed to perform and adhere to Sterling's special stain scheme.

244. Sterling, Yang, Okuniewski, and Lekov entered into an agreement among themselves, implementing a purported policy that "two pathologists would view each case…" and one pathologist either Yang or Lekov primarily would sign the reports where Defendants caused to have false and fraudulent charges for "special stains". As an overt act committed in furtherance of their conspiracy, Defendants created and disseminated false and fraudulent pathology reports based on their agreement, including reports for Patients 1-5 in Section VII.

245. Yang, Lekov, Okuniewski, and Sterling conspired with Elite, Chang, and Does 1-10 to bill the State's insurance carriers for false special stain codes based on fabricated Pathology reports. All co-conspirators agreed to collect and retain insurance funds for services that did not meet the billing requirements for laboratory services. Defendants verbally directed their employees to electronically transit the false claims or in some cases mail the false claim forms to the carriers for payments.

246. Elite Medical Billing Corporation and Jenny Chang agreed with Defendants to enter the false claims, process upcoded entries, and electronically transmit false remittances for insurance payment. In exchange for their role in Sterling's fraud, Elite and Chang retained 5-6% of gross collections from Sterling's unlawful billing. As an overt act committed in furtherance of their conspiracy, Defendants created and transmitted false and

fraudulent health care claims for payment based on their agreement, including insurance billing for Patients 1-5 in Section VII.

247. As a result of their conspiracy, Sterling, Yang, Lekov, and Okuniewski caused to be submitted false and fraudulent special stains claims, which they knew were neither reasonable nor necessary. Defendants' scheme has evaded insurance carrier and government detection, resulting in severe damages to the State's carriers and taxpayers. The conduct is also ongoing.

248. From at least 2012 onward, all co-conspirators caused the submission of hundreds of thousands of false laboratory claims to the State's insurance carriers in furtherance of their conspiracy.

249. Accordingly, Defendants knowingly conspired to defraud the insurance carriers by getting false or fraudulent claims allowed or paid.

250. By reason of the false or fraudulent claims that Defendant conspired to get allowed or paid, or by reason of its conspiracy to violate the IFPA, the State claims substantial damaged in an amount, to be proven at trial.

E. FIFTH CLAIM

UNJUST ENRICHMENT

By Plaintiff Against All Defendants and Does 1-10

251. Plaintiff repeats and re-alleges all preceding paragraphs of the Complaint inclusive, as if fully set forth herein.

252. Defendants unjustly received and retained payments based on fraudulently submitted claims using fraudulent records. Given the circumstances surrounding Defendants' receipt of these funds, it would be inequitable and unconscionable to allow Defendants to retain such monies. The precise amount of these funds will be determined at trial.

253. Sterling claimed a capacity for performing "33,000" COVID-19 tests per week, all compensated by the State's insurance carriers, and otherwise through the CARES Act and the HRSA COVID-19 Uninsured Program.

254. During 2021 and 2022, Sterling caused to be collected more COVID-19 samples than they could test due to their illicit marketing and recruitment practices. Despite lacking the resources required to timely or adequately process these specimens, Sterling continued to collect samples. Consequently, Sterling was unable to process numerous specimens and failed to provide results, despite billing carriers and the COVID-19 emergency funds for all collected patient demographics, regardless of whether or not testing was performed.

255. Knowing the potential for the discovery of their fraudulent activities, especially during the COVID-19 pandemic, Defendants proactively orchestrated a complex network of shell companies, corporate entities, bank accounts, and foreign trusts and investments to distribute, divert, and conceal their ill-gotten gains. This scheme was designed to hide the tens of millions of dollars obtained from the State's carriers and the government through their deceptive laboratory billing practices.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff the State of California and Relator pray for judgment against Defendants jointly and severally as follows:

(1) Judgement as to Counts One-Five under the California Insurance Frauds Prevention Act Insurance §1871.7, for the amount of the State of California's damages, trebled as required by law, and such civil penalties of Ten Thousand Dollars ($10,000), plus an assessment of not more than three times the amount of each claim for compensation, as defined in Section 3207 of the Labor Code or pursuant to a contract of insurance;

(2) Judgment in an amount equal to three times the amount of each claim for compensation submitted by the Defendants from the commencement of the statutory period through the time of trial;

(3) A civil penalty of $10,000 for each violation of Insurance Code §1871.7 from the commencement of the statutory period through the time of trial;

(4) Disgorgement of any and all profits unlawfully acquired by Defendants;

(5) An award to Relator of the maximum amount allowed pursuant to Insurance Code §1871.7 (e)(5) and Attorneys' fees, expert fees, expenses and costs of suit herein incurred, pursuant to Insurance Code section 1871.7;

(6) Declaratory and Injunctive Relief (Ins. Code Section 1871.7(b));

(7) An injunction against each of the defendants for any continuing conduct violating Insurance Code §1871.7(b);

(8) An order directing Defendants to cease and desist from violating California Insurance Code §1871.7; and

(9) That by reason of Defendants' unjust enrichment, the Court enter an order requiring Defendants to disclose and disgorge all monies they received as a result of the illicit scheme described herein including those in foreign accounts.

Damages sought will are in excess amounts of the jurisdiction of this court and will be in amounts to be proven at trial.

DEMAND FOR JURY TRIAL

Relator demands a jury trial in this case on behalf of Plaintiff the State.

LAW OFFICES OF GLORIA JUAREZ

Dated: June 29, 2023

S/ Gloria Juarez

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ATTORNEYS FOR RELATOR AMERICAN INTEGRA LLC

CERTIFICATE OF SERVICE

I hereby certify that on June 29, 2023, I caused a true copy of **FIRST AMENDED COMPLAINT** the in the matter captioned **THE STATE OF CALIFORNIA EX REL. AMERICAN INTEGRA V. STERLING PATHOLOGY MEDICAL CORPORATION ET. AL.** to be electronically served upon the following,

Person(s) and/or Entity(s) to whom served:

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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed in Laguna Niguel, CA.

S/GJuarez
Gloria M. Juarez