

IN THE COURT OF COMMON PLEAS OF PHILADELPHIA COUNTY

TRIAL DIVISION

IN RE : MISC. NO. 0003299-2010
COUNTY INVESTIGATING :
GRAND JURY XXIV : C-5

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**ACTIVE CRIMINAL RECORDS
CRIMINAL MOTION COURT**

FINDINGS AND ORDER

AND NOW, this ^{11th} day of January, 2012, after having examined the Presentment of the County Investigating Grand Jury XXIV this Court finds that the Presentment is within the authority of the Investigating Grand Jury and is otherwise in accordance with the provisions of the Investigating Grand Jury Act, 42 Pa.C.S. §4541, et. seq. In view of these findings, the Court hereby accepts the Presentment and orders it sealed until further order of the Court. At that time, the Presentment shall be unsealed and the Court will refer it to the Clerk of Court for filing as a public record.

BY THE COURT:



GEORGE W. OVERTON
Supervising Judge
Court of Common Pleas

I HEREBY CERTIFY the foregoing to be
a true and correct copy of the original
office: as filed in this

Date: 1/11/12



Active Criminal Records
Criminal Motion Court Clerk
Erie, Judicial District of Pa.

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PRESENTMENT

TO THE HONORABLE GEORGE OVERTON, SUPERVISING JUDGE OF THE
COUNTY INVESTIGATING GRAND JURY:

We, County Investigating Grand Jury XXIV, were empanelled pursuant to the Investigating Grand Jury Act, 42 Pa.C.S.A. § 4541 et. seq. This Grand Jury was tasked with investigating whether The Pain Center (“Pain Center”), Dr. Owen Rogal, and Kim Rogal (a/k/a Kim DeOliveira) were involved in submitting fraudulent bills to numerous private insurance companies. The allegations centered around the improper use of a specific Current Procedural Terminology (“CPT”) code on bills submitted to the insurance companies in question.

We heard from numerous witnesses, including a Philadelphia County detective assigned by the Insurance Fraud Unit of The Philadelphia District Attorney’s Office to investigate the Pain Center, Dr. Rogal and Kim Rogal; a CPT coding expert; a neurosurgeon; physicians; insurance company investigators; and insurance company claims representatives. We also reviewed documents and billing records that were obtained during our investigation. The testimony and evidence established that between May 8, 2002 and January 4, 2011 the Pain Center, along with Dr. Rogal and Kim Rogal,

routinely falsified health claim forms with the wrong CPT code submitted to numerous private insurance companies. We believe that the purpose of falsifying these claim forms with the wrong CPT code was for monetary gain.

The Pain Center, under the direction of Dr. Rogal and Kim Rogal, employed physicians to perform a procedure that they called Radiofrequency Surgery (“RFS”). The below paragraphs, from Pain Center documents that were marked as Grand Jury exhibits, describe the procedure that the Pain Center claimed it was performing:

The RFS technique developed by The Pain Center is actually a modification of the traditional Radiofrequency technique. The traditional radiofrequency technique focused upon the treatment of nerves, specifically facet joint nerves. The results of this technique have been variable, from no pain relief to temporary pain relief.

The RFS technique developed by The Pain Center focuses on the treatment of muscle injury. The pain relief that has been accomplished with the RFS technique is far superior to the pain relief when the treatment is done on muscle as compared to the treatment of nerves. The goal of the pain relief of the RFS technique will provide permanent pain relief in the areas treated, even in difficult cases.

There are actually two parts to the RFS technique:

1. The first part is the Novocain test performed by the board certified anesthesiologist that the doctors perform when the patient first comes to The Pain Center. The prognostic test performed on the muscle injury, under Fluoroscopic guidance, that can tell the patient even before the treatment, that the RFS technique will be successful in relieving their pain. The results of the Novocain test will be documented.
2. The second part is the RFS technique itself. Very simply, a needle is placed in the same location, the muscle insertion injury where the Novocain successfully decreases the pain. The RFS needle is the same as the Novocain needle only the RFS needle is connected to a machine. When the doctor has correctly positioned the RFS needle, turns on the machine, the end of the RFS needle produces the radiofrequency waves, to create a temperature (80-90 degrees) to relieve the pain. Several lesions (13-20) will be created [*sic*].

The Grand Jury heard testimony about the Pain Center's¹ billing practices, specifically the Pain Center's use of CPT code 61790 for RFS starting in the early 1990s and continuing through to January 4, 2011. The Grand Jury also viewed billings sent to insurers by the Pain Center. The Grand Jury heard from witnesses that explained that the actual procedure defined by CPT code 61790 is a type of brain surgery that requires specialized training and is usually performed by a neurosurgeon in a hospital due to the risk inherent in the procedure.

The Grand jury also heard from witnesses that described the difference in payment for the procedure defined by CPT code 61790 and the actual procedure being performed at the Pain Center by the doctors employed by Kim Rogal and Dr. Rogal. The Pain Center charged \$4,800 per visit/ per patient, using CPT code 61790 for the RFS treatment in the majority of bills it prepared. Additionally, the Pain Center charged inappropriately for several other CPT codes. If the Pain Center had been billing the correct code for the RFS procedure that they were actually performing, it would have charged approximately \$800 per patient/ per visit.

The Grand Jury heard evidence that 15 insurance companies were billed using CPT code 61790 for this RFS procedure by the Pain Center. The total amount billed for CPT code 61790 to these 15 companies was in excess of four million dollars, despite repeated warnings to the Pain Center from numerous companies that they were billing an improper code.

¹Unless otherwise indicated, the Pain Center refers to Dr. Rogal and Kim Rogal.

The Grand Jury also viewed correspondence between the Pain Center and several insurance companies. The correspondence shows that the Pain Center was clearly notified that they were using CPT code 61790 improperly and continued to do so for years after being notified. In addition to insurance companies, the federal government and Medicare also told the Pain Center that they were incorrectly using CPT code 61790. The federal government reached a civil settlement with the Pain Center in 2006, which required the Pain Center to pay the federal government approximately \$269,000. The Pain Center responded with several arguments in an attempt to justify their use of this code, including an argument about placement of a semi-colon in the descriptive explanation of the code that appears in the CPT Codebook. Based on the testimony we heard and the documents we reviewed, we find these arguments have no merit.

Dr. Frank Dubeck, Excellus Blue Cross/ Blue Shield

Dr. Frank Dubeck testified before the Grand Jury. Dr. Dubeck is a physician employed by Excellus Blue Cross/Blue Shield (“Excellus”), who is in charge of clinical editing, coding, and technology assessment. He has worked at Excellus for 11 years. Dr. Dubeck graduated from Cornell University (chemical engineering degree) and Georgetown University (medical degree). He did his residency at University of Pittsburgh, followed by four years in the Air Force as a Major Chief of medicine in Nebraska. Following the Air Force, he practiced internal and geriatric medicine in private practice for twelve years.

In addition to his job at Excellus, Dr. Dubeck sits on the American Medical Association's CPT Editorial Panel. This is the group that meets to approve the CPT codes and language in the CPT Codebook produced by the American Medical Association ("AMA"). Dr. Dubeck testified that the CPT Codebook contains approximately eight thousand codes that describe procedures performed by physicians. Since medicine is always evolving, there may be procedures developed that do not have a CPT code assigned. If there is not a CPT code for the performed procedure, physicians are instructed to use the "undefined²" codes in the CPT Codebook. In early 2000 the federal government declared the CPT Codebook to be the official code set used by physicians to report their services to insurers. Additionally, there is a process by which specialty societies, individual physicians, and interested third parties can petition the board for a new code, if there is no code to meet their needs.

Dr. Dubeck then explained how monetary values are assigned to each code. He stated that each code is assigned a "Relative Value Unit" (RVU). The CPT board has a committee to set these values. The values are set by examining three components of the procedure in question. The first component is practical expense: equipment, staff, heat, and light costs, etc. The second component is physician work: how difficult the procedure is, how much training is required, and the skill level required to perform the

² The CPT Codebook defines unlisted procedures as "services or procedures performed by physicians . . . that are not found in the CPT codebook." During testimony witnesses referred to these codes as unspecified, unlisted, or undefined. They are at the end of each section in the CPT Codebook.

procedure. The last component is malpractice expense: the riskier the procedure, the higher the physician's malpractice expense.

Dr. Dubeck became aware of what he called "billing irregularities" coming from the Pain Center in Philadelphia for claims on behalf of a patient insured by his company. Dr. Dubeck stated that the Pain Center was billing CPT code 61790. CPT code 61790 defines a procedure that involved destruction of neural tissue in the center of the brain, from behind the eye and in front of the ear. He testified that the procedure is usually done in a hospital setting, by a neurosurgeon with special equipment. Based on his review of the paperwork submitted by the Pain Center, doctors at the Pain Center performed RFS on the patient's neck, back, and hips, but none to the area of the skull.

Dr. Dubeck read the exact language contained in the CPT Codebook for CPT code 61790: "Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); gasserian ganglion." Dr. Dubeck stated that "stereotactic method" means an x-ray that is capable of looking at an area from two different angles at one time, at 90 degree angles. He explained that this differs greatly from a standard fluoroscopic view which is done using only one view. "Percutaneous" means using a needle and not opening an incision. "Neurolytic agent" refers to the destruction of nerve tissue by methods such as alcohol, thermal, electrical, or radiofrequency. "Gasserian ganglion" refers to a mass of nerves in the head. While discussing the CPT Codebook, Dr. Dubeck spoke about the instructions for using the book appearing at the beginning of the book. The instructions for use of the CPT

Codebook read as follow: “Select the name of the procedure or service that accurately identifies that procedure performed. Do not select the CPT code that merely approximates the service provided.”

Moreover, Dr. Dubeck explained that the AMA keeps Medicare statistics on the types of facilities at which the CPT code 61790 procedure is performed and the types of “specialties” that perform it. Based on 2008 Medicare statistics, the procedure is performed 70 percent of the time as an outpatient procedure in a hospital, 21 percent of the time as an inpatient procedure in a hospital, seven percent of the time in an ambulatory surgical center; and less than half a percent of the time in a physician’s office. The “specialties” that billed for the CPT Code 61790 procedure are neurosurgery (94.74%), interventional pain management (2.26%), neurology (1.20%) , multispecialty clinic or group practice (0.75%) anesthesiology (0.45%), pain management (0.30 %), and nuclear medicine (0.30%).

Dr. Dubeck explained that his company, and most insurance companies, use automated claims systems that process claims electronically. The automated claim systems are set up to pay the physician, because insurance companies proceed on the assumption that physicians are billing honestly. Claims are only examined more closely if the physician is suspected of using an incorrect code. Dr. Dubeck testified that, at some point, it came to the attention of Excellus that the billings from the Pain Center were submitted using CPT code 61790³. These billings were then examined manually by

³ Dr. Dubeck stated that it was a red flag that Dr. Rogal never pursued payment from the patient, despite believing he was owed the money.

a person rather, than through the automated system. Further documentation was requested and received from the Pain Center, including operative reports and doctor's notes. The doctor's notes and operative reports did not justify the billing of CPT code 61790. Excellus determined, based on the Pain Center's documentation, that the Pain Center was not performing any procedure on the gasserian ganglion. Therefore, Excellus began denying payment of the bills for CPT code 61790 submitted by the Pain Center.

The Pain Center sent a letter to Excellus defending their use of the code and demanding payment. The Pain Center argued that they were performing the exact same procedure specified in the code, except they weren't doing the procedure on the gasserian ganglion. Dr. Dubeck responded to their letter stating that the Pain Center was using a CPT code that didn't fit the procedure they were performing. Dr. Dubeck explained that the Pain Center was not treating the gasserian ganglion and the risks involved in treating the gasserian ganglion were much greater than the risks involved in treating other areas of the body. Dr. Dubeck instructed the Pain Center that they should be using an unlisted code, and he told them that he would approve payment if they billed CPT code 64640, which he believed to be a much closer description of the procedure being performed by the Pain Center.

Using 2008 Medicare numbers, Dr. Dubeck explained that CPT code 61790 would be valued at approximately \$800 per unit and CPT code 64640 would be valued at approximately \$209 per unit. Dr. Dubeck concluded that, due to the Pain Center's fraudulent billing of CPT code 61790, Excellus had paid out approximately \$178,000 to

the Pain Center. If the Pain Center had correctly coded the bills, Excellus would have paid out approximately \$28,000. Thus, the Pain Center overbilled in the amount of \$150,000 in connection with the one patient insured by Excellus.

Carol Pohlig, Coding Expert

Carol Pohlig, a coding expert, testified before the Grand Jury. Pohlig is employed as a senior coding and education specialist at The Hospital of The University of Pennsylvania Department of Medicine, where she helps medical providers document and bill for their services. Pohlig has a degree in nursing and she is a certified coder from the American Academy of Professional Coders and The Board of Specialty Coding.

Pohlig explained the AMA's CPT coding system and CPT Codebook to the Grand Jury. A CPT code is a series of five digit codes that describe procedures performed by medical providers. CPT codes are used to identify procedures for billing purposes and they are listed in the CPT Codebook. There is a new edition of the CPT Codebook published every year. Pohlig stated medical providers and coders are obligated to use the current year edition of the CPT Codebook to report services. When choosing a CPT code to bill, the procedure performed must match the code in the CPT Codebook exactly. She further stated that it is not an approximation or "how close you can get to the code." If the medical provider did not perform the service that is associated with a particular code, the medical provider can not bill the code. If there is no code in the book that fits exactly the service the medical provider is performing, the medical provider should use an unlisted

CPT code. By using the unlisted code, the medical provider is telling the insurance company that they performed a procedure that is not described in the book.

Carol Pohlig then spoke about RVU values. She described RVU values as a way to put a value on each CPT code. These RVU values are set by a committee that is part of the AMA. Pohlig gave an example of two procedures: a vaccination shot and an injection into a patient's spine. She stated that the RVU value for injection to the spine would be greater than the RVU value for a vaccination. When determining the RVU, the AMA committee takes into account the following factors: physician work effort, practice expense (overhead cost of the procedure), and malpractice expense (risks of something going wrong). She testified that CPT code 61790 has an approximate value of 25 total points: 11 ½ or 12 of those points are for physician work effort and the remaining points are to cover practice expense.

Pohlig then explained that a payer (insurance company/ Medicare) creates a fee schedule based on the RVU values. This is done by placing a dollar value on each RVU value. For example, if the dollar value per one RVU value is \$37.00, then a procedure assigned RVU value of one would pay \$37.00. An RVU value of 10 would pay \$370.00. A simple vaccination may be assigned RVU value of one and, therefore, the payer would pay \$37.00. The injection into the spine may be assigned RVU value of 10 and, therefore the company would pay \$370.00. Moreover, Pohlig testified that she believed the RVU value for CPT code 61790 is approximately 25. Medicare's fee schedule, based on RVU

values, would pay the doctor approximately \$938.00 per unit for RFS performed on the gasserian ganglion in the brain.

Pohlig then explained the CPT code 61790 as a procedure during which a needle is inserted through the skin into a portion of the brain to destroy a nerve, either by injection of alcohol, thermal-electrical or radiofrequency. She explained the wording of the code to the Grand Jury as follows: "Creation of lesion by stereotactic method, percutaneous, by neurolytic agent such as alcohol, thermal, electrical, radiofrequency; particular to the gasserian ganglion." She went on to explain to the Grand Jury that CPT code 61790 is considered to be a major surgical procedure. She stated that with this code, as with any major surgical procedure, the cost built into the code includes a post operative period of 90 days. Therefore, any follow up care related to this procedure is included within the payment made to the physician for this procedure. This is why CPT code 61790 is weighted so heavily in value.

Pohlig then testified about several Pain Center patients' medical records that she had reviewed prior to appearing before the Grand Jury. Included in the reviewed records, were doctors' notes, operative reports, and billing records. After reviewing the records, Pohlig stated that there was nothing in the records that would justify the use of CPT code 61790, as there was no treatment to any patient's gasserian ganglion. She stated that, in her opinion as a professional coder, each of these procedures should have been coded using a CPT code in the 6400 series of the CPT Codebook. The 6400 series lists procedures dealing with destruction of nerves by neurolytic agent, which Pohlig thought

most closely resembled the Pain Center procedure. Several codes in the 6400 series would be applicable, depending on which part of the body the physician was treating. She went on to state that CPT codes in the 6400 series pay between \$180.00 to \$240.00, depending on which area of the body was being treated. She stated that the total RVU values for the procedures in the 6400 series are about an 11 versus the approximate RVU value of 25 for CPT code 61790. Pohlig then went on to state that she did not understand the reasoning used by the Pain Center to charge four units of code 61790. She stated that even if a doctor was legitimately using the CPT code 61790, they could not bill for more than two units during a single visit, because the gasserian ganglion can only be treated once on the right side and once on the left side.

Pohlig also spoke about the other CPT codes billed for by the Pain Center as part of the procedures that they claimed they were performing. She explained that CPT code 99070 is a code covering supplies in addition to those which would normally be used to perform the procedure being billing for. She explained that a medical provider can only bill CPT code 99070, in addition to the main CPT procedure code, when the medical provider uses supplies that are not typical to the primary procedure. Pohlig explained that CPT code 99199 is a code for a “special report.” She stated that she did not know why the Pain Center was using this code, as a doctor’s report is part of normal doctor’s work. After reviewing the Pain Center paperwork, she was not sure what the Pain Center considered to be a “special report” for the purposes of CPT code 99199. She concluded

that based on the Pain Center documentation, there would be no reason for the Pain Center to bill these additional codes.

Pohlig then addressed the Pain Center's "semi-colon" argument regarding CPT code 61790. In defense of its billing practices, the Pain Center has repeatedly argued in correspondence to insurance companies that they are in fact performing a procedure that CPT code 61790 applies to, because they are performing the "common portion of the code." The Pain Center claims that CPT code 61790 is the correct billing code, since the procedure they perform includes everything up to the semi-colon in the CPT code description. According to the argument made by the Pain Center, the part of the body on which the procedure is performed is irrelevant to determining the value and cost of the procedure. Following that logic, they justify billing the same amount for a procedure involving insertion of a needle into a leg muscle as the CPT code allows for an invasive procedure to the brain. Pohlig rejected the Pain Center's argument and stated that what follows the semicolon is a very important part of this code. She showed the jurors the example at the introduction of the CPT Codebook. Under the heading of Format of the Terminology, the CPT Codebook reads as follows:

. . .some of the procedures in the CPT codebook are not printed in their entirety but refer back to the common portion of the procedure listed in the preceding entry. . .[] in an effort to preserve space.

Example [from the book]

25100 Arthrotomy, wrist joint; with biopsy

25105 with synovectomy

Note the common part of code 25100 (the part before the semicolon) should be considered part of code 25105. Therefore, the full procedure represented by code 25105 should read [if space wasn't an issue]:

25105 Arthrotomy, wrist joint; with synovectomy

Pohlig testified that the common procedural description is applied to a series of codes that are part of the same procedural service.

In the case of CPT code 61790, the semicolon refers to the part of the body on which the procedure is being performed: gasserian ganglion. CPT code 61791, the following code, refers to the same procedure performed on a different part of the body: trigeminal medullary tract. The CPT Codebook reads as follows in the Surgery/ Nervous System Chapter:

61790 Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radifrequency); gasserian ganglion.

61791 trigeminal medullary tract

Therefore, if space was not an issue, CPT code 61791 would read as follows:

61791 Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency);trigeminal medullary tract

Dr. John Y. K. Lee, Neurosurgeon

Dr. John Y.K. Lee testified before the Grand Jury that he is a neurosurgeon at The Hospital of The University of Pennsylvania (“HUP”). He attended Yale University and University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School. After four years of medical school, he spent seven years training to be a neurosurgeon at the University of Pittsburgh. He then trained for an additional six

months at the Cleveland Clinic in stereotactic neurosurgery. In addition to seeing patients at HUP, he is also an assistant professor.

Dr. Lee testified that one of his specialty interests is in the treatment of trigeminal neuralgia, which he described as a “horrible facial pain.” He believes that he is the only neurosurgeon in the city with this specialty interest and he treats approximately 200 -300 patients a year for trigeminal neuralgia⁴. He stated that one of the treatments that he performs for the relief of trigeminal neuralgia is surgery to the gasserian ganglion (cell body at the base of the skull): a gasserian ganglionectomy. Surgery on this area is done as a last resort when all other courses of treatment have failed. Therefore, he only performs this surgery about five times a year. Dr. Lee testified that a gasserian ganglionectomy is the procedure that would be billed using CPT code 61790.

Dr. Lee performs the CPT code 61790 procedure in a hospital operating room. The patient is intubated (i.e. a breathing tube is inserted into the patient.) The patient is under general anesthesia, administered by an anesthesiologist. He went on to describe this dangerous procedure as inserting a needle, approximately five to six inches long, up through the cheek into the skull through a hole where the nerve sits and then damaging the nerve with either radiofrequency, chemical, or alcohol. The purpose of damaging the nerve is to relieve the facial pain from trigeminal neuralgia. Dr. Lee described it as risky surgery, because there is a possibility of striking an artery with the needle and causing a stroke, and maybe even death. The surgery can cause a patient to have seizures or their heart to stop beating.

⁴ There may be a doctor at Abington Hospital that performs the CPT code 61790 needle procedure.

Dr. Lee testified to the Grand Jury that trigeminal neuralgia generally only strikes one side of the head at a time. He stated that it is extremely rare to treat both sides at the same time and that he has never treated both sides at the same time. Therefore, it would be extraordinarily unusual to bill for more than one unit of CPT 61790 at any given time. He went on to state, that if some of the treated nerve is left behind, it can grow back. Dr. Lee testified that the soonest he would perform the surgery a second time would be a year after the first surgery, but it would be much more risky the second time.

Dr. Stuart Kauffman, Former Pain Center Doctor

Dr. Stuart Kauffman testified before the Grand Jury. Dr. Kauffman is a physician with a solo private practice. He practices general medicine and pain management. Dr. Kauffman worked as a physician at the Pain Center from around Thanksgiving 2004 until March or April 2006. He was interviewed and hired by Dr. Rogal.

Dr. Kauffman testified that Dr. Rogal is the owner of the Pain Center and his daughter, Kim Rogal, is in charge of billing for the Pain Center. He testified that Dr. Rogal would greet the patients, explain the procedures to the patients, and examine the patients. Dr. Kauffman stated that Dr. Owen Rogal is a dentist by training. Dr. Kauffman explained that he was hired by the Pain Center under contract, to only treat patients. He did not handle billing and he received a salary, plus a bonus of \$50.00 to \$75.00 for each patient treated.

Dr. Kauffman described the RFS procedure that he performed at the Pain Center as a two part procedure. First, he injected a small amount of Novocain into patient's body at the site of the pain. If the patient's pain was reduced by fifty percent, then he would proceed to the second part of the procedure: the radiofrequency treatment. Dr.

Kauffman described the radiofrequency treatments as “injection procedures” during which he would insert a needle into the area of the patient’s body (spine, neck, back, knee, or shoulder) that was injured. There is a small device (i.e. a probe) that heats the tip of the needle. The heat destroys nerve endings and increases blood flow to the area to help in healing. While working at the Pain Center, he would perform the procedure anywhere there was a joint: spine, neck, low back, knee, ankle, elbow, and shoulder. He did not perform RFS anywhere near the brain and the gasserian ganglian. When he started performing the procedure, it would take him 45 minutes to complete. Currently, he can complete the procedure in about 15 minutes.

Dr. Kauffman then explained that he would fill out several forms for each patient that he treated at the Pain Center. He stated that those forms detailed the treatment that he rendered on each patient visit. He stated that he had no part in the billing or in filling out insurance claim forms.

Dr. Kauffman testified that he left his job at the Pain Center after being contacted by representatives of Blue Cross/Blue Shield of Pennsylvania about the fraudulent billing of CPT code 61790. Blue Cross/ Blue Shield told Dr. Kauffman that the bills being sent to Blue Cross/Blue Shield were for CPT code 61790 (procedure to the gasserian ganglian in the brain) in Dr. Kauffman’s name as the treating physician. Dr. Kauffman knew that he was not treating areas anywhere near the brain and confronted Dr. Rogal about the issue. Dr. Rogal told him that the CPT code was appropriate and referred Dr. Kauffman to his attorney. Dr. Kauffman stated that he spoke with Dr. Rogal’s attorney. Dr. Rogal’s attorney couldn't tell Dr. Kauffman that the code was 100% correct, but the attorney did say that the code could be used because there wasn’t an exact code for the

Pain Center procedure. Dr. Kauffman testified, however, that if an exact code doesn't exist the unspecified code should be used. Dr. Kauffman did point out that the insurance companies will usually only pay minimally for unspecified codes.

Dr. Kauffman went on to testify that after resigning his position at the Pain Center he opened his own practice in Philadelphia. He stated that he performs the same RFS procedure in his own practice that he performed at the Pain Center. He stated that he bills insurance companies using CPT codes in the 6400 series of codes. According to Dr. Kauffman, all other pain specialists are using the same codes that Dr. Kauffman is using in his current practice. He assumes that Dr. Rogal is using a different code than other pain specialists because it pays substantially more money. He went on to state that he has never treated the gasserian ganglion in his practice. He stated that he has seen several patients that he believed to be in need of treatment to the gasserian ganglion and he referred those patients to a neurosurgeon for treatment.

Dr. Mitchell Mednick, Former Pain Center Doctor

Dr. Mitchell Mednick testified before the Grand Jury. Dr. Mednick is a physician and was previously employed by the Pain Center. Dr. Mednick stated that he was hired after separate interviews with Kim Rogal and Dr. Owen Rogal. Dr. Mednick testified that he worked at the Pain Center from April 2009 until November 2010.

Dr. Mednick testified that his duties at the Pain Center consisted of treating pain using a radiofrequency procedure. The patient would first meet with either Dr. Rogal, or a chiropractor, who would determine which area of the body was to be treated. Dr. Mednick, or another doctor, would then do an examination and press on areas where the patient felt the pain. Once the area of pain was pinpointed, Dr. Mednick would numb the

skin around the area to be treated. He would then insert a cannula, a long needle, into the area, with a little anesthesia being released as the needle went into the patient. The cannula would be inserted all the way in to the point where the muscle meets the bone. More anesthesia would be released at that point. Then a thin wire would be sent through the cannula to the point where the muscle meets the bone. This thin wire would be connected to a machine called the 'radiofrequency transducer.' Dr. Mednick explained that the radiofrequency is a form of heat. This radiofrequency signal would heat the tip of the cannula, in turn heating the area being treated for one minute. The cannula was then repositioned by pulling it out of the patient a fraction of an inch. The cannula was not pulled all the way out of the skin. This repositioning would be done approximately three to five times. This entire procedure was done using x-ray guidance so that the treating doctor could see where the needle was at all times. Dr. Mednick stated that only one spot on a patient's body was treated during each visit. Dr. Mednick stated that during the procedure the chiropractor, and sometimes Dr. Rogal, was in the room with him. Dr. Mednick and Dr. Rogal would have disagreements during treatment of a patient when Dr. Rogal would try to tell Dr. Mednick how to move the needle. When Dr. Mednick would disagree with Dr. Rogal, Dr. Rogal would grab Dr. Mednick's hand and attempt to move the needle. On at least one occasion, Dr. Mednick stated he had to physically push Dr. Rogal away from him during a procedure.

Dr. Mednick then testified that his responsibilities consisted of treating patients only. He would treat patients and fill out paperwork documenting the treatment that he performed on the patient. He stated that the billing was the responsibility of the Pain Center. Moreover, Dr. Mednick stated that once a year he would receive an Internal

Revenue Service (“IRS”) form from the Pain Center. Dr. Mednick explained that the Pain Center would send out each bill in the treating doctor’s name. The reimbursement checks from the insurance companies would come directly to the Pain Center in that doctor’s name. However, those checks would not be given to the doctor, they would be retained by the Pain Center. An IRS form was issued to remove that income from the individual doctor’s tax identification number and move the income to the tax identification number used by the Pain Center.

Dr. Alexander Kiotis, Former Pain Center Doctor

Dr. Alexander Kiotis testified before the Grand Jury that he is a physician who is currently in private practice in Media, Pennsylvania. The Pain Center employed Dr. Kiotis from October 2003 to June 2004. When Dr. Kiotis applied for a position at the Pain Center, he was interviewed by Dr. Owen Rogal, along with another physician employed by the Pain Center. Dr. Kiotis was paid a salary by the Pain Center and he did not receive bonuses for patients treated. Dr. Kiotis stated that during his tenure at the Pain Center, he was also operating his own private practice in Upper Darby, Pennsylvania.

Dr. Kiotis testified that he performed radiofrequency treatments on approximately three to four patients a day at the Pain Center. Usually, he would perform a physical exam on the patient and review the patient's chart and notes from prior visits. During that examination, he would attempt to pinpoint an area of pain to treat that day. The patient would then be injected with lidocaine. If the lidocaine injection relieved the pain, the next step would be the radiofrequency treatment. He stated that the injection part of the procedure was quite simple, as he had been giving injections to patients in his own

practice for fifteen years. He stated that the radiofrequency was an additional part of the injection. He described the radiofrequency as introducing a catheter which added a small amount of heat to the area being treated. Dr. Kiotis stated that, for each patient he saw, he would fill out three or four forms, each detailing the treatment given. Dr. Kiotis stated that he never filled out or saw insurance claim forms for the patients.

Dr. Kiotis stated that he left the employ of the Pain Center after being contacted by representatives of Highmark Blue Cross/Blue Shield ("Highmark"). He believes that Highmark first contacted him by mail in reference to billings submitted in his name by the Pain Center. He contacted Highmark after receiving the correspondence and set up an appointment to meet with them. Dr. Kiotis and his attorney met with representatives from Highmark in Dr. Kiotis's office in Upper Darby, Pennsylvania. During the meeting, Highmark informed Dr. Kiotis that the Pain Center was submitting bills under his name for patients he had treated. Moreover, Highmark told him that the Pain Center submitted such bills using a code for a neurological procedure. Highmark presented Dr. Kiotis with pictures and documentation regarding the procedure that the Pain Center was billing. Dr. Kiotis testified that the procedure that he performed at the Pain Center should have been valued in the range of \$300 to \$400. He testified that he was surprised when Highmark informed him that the Pain Center bills were being submitted for thousands of dollars. He was "incredulous" over the billing issues. Dr. Kiotis testified that he had a conversation with Dr. Rogal regarding the neurological code being used in the bills. He testified that, when he asked Dr. Rogal about the coding, Dr. Rogal's reply was that there was no commensurate code for the Pain Center's procedure. Dr. Kiotis stated that Dr.

Rogal said the use of the neurological code was appropriate because it was the closest CPT code to their procedure.

Dr. Kiotis stated that after leaving his position at the Pain Center he had problems with the Internal Revenue Service. He stated that income received by the Pain Center for treatments rendered by him had been attributed to his taxpayer identification number, and counted as his personal income. Dr. Kiotis stated that he never received any payment, other than his agreed upon salary from the Pain Center. Dr. Kiotis testified that he was able to resolve the problems with the Internal Revenue Service.

Dr. Catherine Maturo, Former Pain Center Doctor

Dr. Catherine Maturo testified before the Grand Jury. She is a 1999 Graduate of The Philadelphia College of Osteopathic Medicine, and is a board certified physician. The Pain Center employed her from April or May of 2007 until April or May of 2008. She states that she was hired after being interviewed by both Dr. Owen Rogal and Kim Rogal. She stated that she did not know that Dr. Rogal was a dentist until she had been employed there for a month or two. She stated that she was a salaried employee and received a bonus if she saw extra patients. Dr. Maturo saw approximately one to five patients a week. When she wasn't seeing patients, she would read medical books, knit or work on the computer.

Dr. Maturo told the Grand Jury that she performed "radiofrequency surgery" at the Pain Center. She described RFS as a procedure that uses radio waves to divert the pain signal and alleviate the pain in the area being treated. She states that she spent the first two or three weeks observing before she performed the procedure. She explained

the procedure as a complicated minimally invasive procedure. She stated that she required no training, other than watching the procedure, prior to performing it herself.

Dr. Maturo described the procedure to the Grand Jury. Dr. Rogal would first speak to the patient. After Dr. Rogal's conversation with the patient, Dr. Maturo or another physician would conduct a physical exam on the patient. The doctor would perform a lidocaine test⁵ on the patient, during which Dr. Rogal would decide if the pain was alleviated by administering lidocaine. If the pain was alleviated, the radiofrequency treatment would begin. She testified that while she performed the radiofrequency portion of the treatment Dr. Rogal would remain in the room. She stated that Dr. Rogal would look through the fluoroscope (similar to an x-ray machine) and Dr. Rogal would tell her where to move the needle to "the north, south, east, or west" on a patient's body.

Dr. Maturo testified that she would only see Kim Rogal, the office manager, when Kim Rogal came upstairs to speak with a patient about insurance issues. Dr. Maturo went on to describe the treatment rooms at the Pain Center as similar to the exam rooms found in a general practitioner's office. The rooms were not hospital operating rooms.

Dr. Frank Grandizio, Former Pain Center Chiropractor

Dr. Frank Grandizio testified before the Grand Jury. Dr. Grandizio testified that he has been a licensed chiropractor for twenty years. The Pain Center employed him for ten years (1992 to 2002). He was hired by Dr. Owen Rogal. He described Dr. Rogal as the owner of the Pain Center, and Dr. Rogal's daughter, Kim Rogal, as the office billing manager.

⁵ See the Pain Center Literature above. Some doctors testified before the Grand Jury to using lidocaine, and other doctors testified to using novacain for the first part of the test at the Pain Center.

Dr. Grandizio testified that around 1995 the Pain Center went from being a high volume personal injury practice to a practice that only performed one service, which he referred to as radiofrequency surgical cauterization. Dr. Grandizio stated that a heated needle would essentially burn an area that might be the source of a pain problem. Dr. Grandizio went on to state that Dr. Rogal attended a seminar regarding radiofrequency treatment. When Dr. Rogal returned from the seminar, he announced, "We are doing this." The Pain Center went from treating 40-70 patients per day to five to seven patients per day after they started performing only RFS.

Dr. Grandizio stated that his role at the Pain Center was to examine the patients prior to the RFS. He would palpate the area of the patient's pain, mark the area of pain, and then take a picture of the area of pain using the fluoroscope. A physician would then do the RFS. Dr. Grandizio would watch and take notes during the procedure.

Dr. Grandizio described the layout of the Pain Center. The treatment area was on the second floor. The billing office was on the first floor, where Kim Rogal worked. He stated that the doctors were not supposed to be in the billing area. Dr. Grandizio stated that he was fired from the Pain Center when Dr. Rogal found out that he was operating his own chiropractic practice in Aston, PA.

Dr. Paul Palmerio, Current Pain Center Doctor

Dr. Paul John Palmerio testified before the Grand Jury. Dr. Palmerio is a physician currently employed at the Pain Center. Dr. Palmerio testified that he has been practicing medicine for close to thirty years. He stated that he started working at the Pain Center in November 2004, after being interviewed and hired by Dr. Rogal. Dr. Palmerio testified that, at the time of his Grand Jury testimony, he was the only physician

employed by the Pain Center. According to Dr. Palmerio, the Pain Center's other employees currently include: Dr. Rogal, Kim Rogal, and some other people handling billing with Kim Rogal.

Dr. Palmerio testified that he is responsible for performing the RFS on patients. Prior to the RFS procedure, he would do a "work up" on the patient. After performing the procedure, he would write out notes pertaining to the treatment given that day. Dr. Palmerio stated that at no time did his responsibilities include either preparing bills or sending bills to insurance companies.

Dr. Palmerio then explained to the Grand Jurors the treatment given to the typical first time patient at the Pain Center. Dr. Palmerio would first perform a general physical exam, during which he would gather medical history. After the brief physical exam, the patient would be taken to another room for the RFS. Dr. Palmerio (or a chiropractor working with him) would then palpate (touch) the area of the body that the patient described as causing the most pain. By touching the area, Dr. Palmerio could pinpoint the area to treat. The skin surface of the area to be treated would be numbed, marked with a marker and then a needle would be placed into the area down to the bone, using the fluoroscope for guidance. Dr. Palmerio testified that a small amount of medication was injected to numb the area. Dr. Palmerio would then have the patient get up from the table and perform whatever procedure usually brings on their pain, whether it be walking, sitting down, or standing up. After five to seven minutes, the patient reports whether the pain is still there or not.

Assuming the pain is gone and the patient's insurance company agrees to pay for the procedure, Dr. Palmerio would perform RFS on the patient. According to Dr.

Palmerio, the needle is placed into the numbed area and a small wire is then placed through the needle to deliver the radiofrequency. The radiofrequency, which is generated by a machine, is pre-set to heat at 176 degrees Fahrenheit. It provides a steady burst of heat to the area for one minute. The entire procedure is done under fluoroscopy and images are taken and printed out for each procedure. The needle is then moved slightly, while still in the body, and the procedure is repeated. The procedure is usually repeated six to eight times per visit on a typical patient.

Dr. Palmerio testified that the procedure was a relatively easy thing for him to learn, as he was familiar with performing injections in his own practice. He testified that he did not need any additional training, other than watching the procedure performed by another doctor at the Pain Center. Dr. Palmerio testified that the procedure would take approximately 45 minutes from start to finish. Dr. Palmerio described the procedure rooms as clean, but not sterile. He stated that they were not what he would consider operating rooms or rooms that would be in a day-surgery center. He explained that operating rooms are sterile environments, and these rooms, that while clean, are not sterile.

Dr. Palmerio testified regarding the CPT codes being used by the Pain Center. He stated that he was unaware that CPT code 61790 was being used by the Pain Center. He stated that there were no procedures done to the gasserian ganglion on any patient. He described the gasserian ganglion as being in the brain. Dr. Palmerio was asked if he would be surprised to find a \$5,150 bill had been submitted to an insurance company for a single RFS treatment he performed on a patient. Dr. Palmerio replied “[t]hat was a gross--as far as I’m concerned--overpayment of bills, which is unacceptable to me.”

Later in his testimony, Dr. Palmerio again described charging \$5,150 for RFS treatment as being “grossly out of proportion, I know what I did, I know how long it took, and I don’t understand how somebody comes up with a \$5,000 bill for a procedure which takes me forty five minutes.”

Dr. Palmerio testified that several months before his testimony in front of the Grand Jury, Kim Rogal asked him to go and speak with her lawyer in reference to a deposition. He testified that he could not remember the name of the lawyer. He went on to state that he accompanied Kim Rogal to the lawyer’s office. The lawyer asked Dr. Palmerio if he knew why he was there and Dr. Palmerio told the lawyer that he did not know why he was there. According to Dr. Palmerio, the lawyer asked Kim Rogal to step out of the room. Dr. Palmerio stated that he had a discussion with the lawyer about a \$500,000 bill from the Pain Center to an insurance company. Dr. Palmerio testified that the lawyer asked Dr. Palmerio if he wanted to get involved in a deposition for Kim Rogal to justify the \$500,000 bill. Dr. Palmerio replied “That’s impossible . . . [t]his is the first time I’m hearing about it. This is crazy.” Dr. Palmerio stated that he then left the lawyer’s office, telling Kim Rogal that he was not doing the deposition. Dr. Palmerio went on to testify that what he was doing was competent and accepted around the world, but the price was just out of line. He said that he could not put a number on it, but a \$500,000 bill was “ridiculous.”

Donna Wadsworth, Pain Center Employee

Donna Wadsworth testified before the Grand Jury. She stated that she was currently employed at the Pain Center and has worked there approximately four years. After being interviewed by Kim Rogal, she was hired to do billing. She would answer

phones and help with other office functions if they were short of staff. She stated that Kim Rogal trained her to do the billing, which was done on a computer. She stated that the billing screen on the computer was reached by clicking on an icon entitled “Kim’s Billing.”

Donna Wadsworth testified that, after being given a patient’s file, she would enter the patient’s identification code from the back of the file into the billing screen. Once the identification number was entered, all of the patient information would appear on the screen. This information included name, address, date of birth, social security number, and insurance company information. She would enter the date that the patient was seen, and how many radiofrequency lesions were done on that day. The CPT codes and dollar amounts would automatically appear once she typed in the number of lesions. She stated that the usual dollar amount that would appear was \$4,800 for the radiofrequency treatment. Sometimes the dollar amount would be less than \$4800 if there were fewer lesions. She would then add the other charges: fluoroscopy, supplies, and materials used for the treatments. Ms. Wadsworth stated that after completing the bills they were printed out and checked by Kim Rogal before being mailed out. Donna Wadsworth testified that she had no experience in medical billing prior to her employment at the Pain Center. She testified that Kim Rogal told her that she did not like to hire people with billing experience.

Donna Wadsworth went on to state that when she began working at the Pain Center she worked a five day work week. The Pain Center cut her from a five day work week to a two day work week in early November 2010. She stated that there was a decline in the number of patients for several reasons: some patients were discharged,

some patients didn't think the procedure was working for them, and some patients stopped coming due to nonpayment of bills by insurance companies. She testified that she heard from another employee that the insurance companies had stopped paying because there was something wrong with the CPT codes that the Pain Center was using.

Detective Karl Supperer, Philadelphia County Detective

Detective Karl Supperer, Badge #105, is currently assigned to the Insurance Fraud Unit (IFU) at the Philadelphia District Attorney's Office. He has been a member of the IFU for three years. Detective Supperer is one of a group of detectives charged with investigating cases referred to the IFU and is well versed in the field of insurance fraud investigations. Referrals to the IFU come from a variety of sources, including complaint calls from the general public, referrals from insurance companies, and referrals from The National Insurance Crime Bureau. (NICB). Detective Supperer has extensive experience investigating criminal matters, having been the assigned investigator or assisting in thousands of investigations during his career. Before becoming a Philadelphia County Detective in 2007, he was employed by the Philadelphia Police Department for 17 years. For 11 years while in the Philadelphia Police Department, he was a detective assigned to the East Division of the city.

Detective Supperer was the first witness to testify before the Grand Jury in this matter. He testified on several occasions before the Grand Jury. Detective Supperer testified that he was assigned by the IFU to investigate a medical practice located at 12th and Lombard Streets in Philadelphia. The practice, the Pain Center, was described as being operated by a Dentist, Dr. Owen Rogal and Dr. Rogal's daughter, Kim Rogal.

Dr. Rogal owns the Pain Center and Kim Rogal is the office manager for the Pain Center. She handles the billing of the insurance companies. Kim Rogal also owns the building that houses the Pain Center.

Detective Supperer testified that the IFU received this investigation as a referral from The National Insurance Crime Bureau ("NICB"). The investigation focused on the use of CPT code 61790, which according to the Detective's testimony is normally applied to a complicated high risk procedure done to an area of the brain. This CPT code was being used over and over again by the Pain Center for a procedure that they were performing on patients suffering from mainly back or neck injuries. The allegation was that the Pain Center was utilizing an inappropriate CPT code in order to overbill for the procedure actually being performed.

Detective Supperer went on to explain that AMA produces the CPT Codebook. The CPT Codebook lists numerous CPT codes to describe medical procedures commonly performed by doctors. The CPT Codebook is the book used by doctors for billing purposes. The Detective went on to state that there are also "unlisted" codes in this book. The unlisted codes are to be used if a CPT code does not exist to accurately describe the procedure that the doctor is performing.

Detective Supperer testified that at the time of his testimony he was in possession of hundreds of bills submitted to insurance companies by the Pain Center, all using the CPT code 61790. The Detective stated that he also had the medical records

corresponding to the bills, and none of them documented an invasive procedure done to an area of the brain, as described by CPT code 61790.

Detective Supperer explained to the Grand Jury that the bills submitted to the insurance companies by the Pain Center were sent using the names and taxpayer identification numbers of the individual physicians employed by the Pain Center to perform procedures. Detective Supperer stated that the doctors performing the procedures were hired by the Pain Center on a salary basis to perform the radiofrequency treatments and claimed no knowledge of how the procedure was being billed by the Pain Center.

Detective Supperer testified that he believed that the billings were produced by the Pain Center. Detective Supperer based this belief on the fact that all of the correspondence regarding billing that was sent to insurance companies, that he had seen, was sent by the Pain Center. When a letter was sent by an insurance company in a doctor's name, the response letter came from Dr. Rogal and Kim Rogal, with the majority of the correspondence bearing Kim Rogal's name. Detective Supperer presented numerous letters to the Grand Jury from the insurance companies, regarding the use of CPT code 61790.

Detective Supperer testified that on November 22, 2010 he, along with other members of the IFU, went to 501-507 S. 12th St in Philadelphia and served a search warrant at the Pain Center. This search warrant was reviewed and signed by the supervising judge of this Grand Jury. Copies of this search warrant were circulated to

members of the jury for their review. Detective Supperer stated that during service of this warrant, he recovered approximately 55 boxes of medical files, business records, and numerous computers, which Detective Supperer turned over to a computer technician for analysis. He stated that in reviewing the records seized he was able to identify approximately twenty insurance companies that had been billed by the Pain Center using the 61790 CPT code. Additionally, he testified that both Kim Rogal and Dr. Rogal's computers contained correspondence in which they were defending the use of CPT 61790.

Detective Supperer testified that he then began to go through each medical file and identify the coding used, the insurance company involved, and compare the treatment notes to the billing code used. In each case, CPT code 61790 was billed to the insurance companies. He testified that he then began contacting the insurance companies in question and requesting copies of bills sent by the Pain Center involving these patients, along with any correspondence between the Pain Center and the insurance companies related to these claims.

Detective Supperer testified that he was able to obtain paperwork, from both files taken from the Pain Center during service of the search warrant and from the affected insurance companies, all of which showed that the Pain Center submitted claims using CPT code 61790 fraudulently in the sixty five cases listed below. (Cases categorized by insurance company, number of patients billed to that company by the Pain Center, total dollar amount of CPT code 61790 billings, and amount paid to the Pain Center for the insured patient(s)):

COMPANY	#OF PATIENTS	CPT 61790 BILLINGS	PAYMENT
NJ Pliga	1	\$24,000.00	\$0
Ace Property & Casualty	1	\$4,800.00	\$4,137.46
Liberty Mutual	1	\$43,200.00	\$42,117.45
PMA	1	\$96,000.00	\$114.92
Excellus BC/BS	1	\$295,200.00	\$126,781.21
Allstate	1	\$25,200.00	\$0
Horizon BC/BS	14	\$1,128,000.00	\$322,567.80
Aetna	23	\$1,269,600.00	\$226,568.35
State Farm	5	\$244,800.00	\$8,186.54
Mega Life and Health	1	\$110,400.00	\$48,741.71
Comp Services	1	\$452,400.00	\$90,789.16
NJ Skylands	1	\$283,200.00	\$0
Blue Cross Michigan	2	\$211,200.00	\$80,178.94
Independence B/C	11	\$91,200.00	\$38,131.50
Selective	1	<u>\$105,600.00</u>	<u>\$57,394.00</u>
	TOTALS	\$4,384,800.00	\$1,045,709.04

The Pain Center billed other codes fraudulently as well: CPT Codes 99070 and 99199.

CPT Code 99070 is described in the CPT Codebook as “Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)”

CPT Code 99199 is described in the CPT Codebook as “Unlisted special service, procedure or report.” The below chart shows the amounts billed to the affected insurance companies for CPT codes 99070 and 99199 by the Pain Center.

COMPANY	#OF PATIENTS	CPT 99070	CPT 99199
NJ Pliga	1	\$0	\$0
Ace Property & Casualty	1	\$0	\$0
Liberty Mutual	1	\$0	\$0
PMA	1	\$24,596.00	\$23,100.00
Excellus BC/BS	1	\$0	\$0
Allstate	1	\$0	\$0
Horizon BC/BS	14	\$0	\$1,050.00
Aetna	23	\$27,950.00	\$26,250.00
State Farm	5	\$34,658.00	\$32,550.00
Mega Life and Health	1	\$1,118.00	\$1,050.00
Comp Services	1	\$0	\$0
NJ Skylands	1	\$64,844.00	\$60,900.00
Blue Cross Michigan	2	\$2,236.00	\$2,100.00
Independence B/C	11	\$10,046.00	\$9,450.00
Selective	1	<u>\$24,596.00</u>	<u>\$23,100.00</u>
	TOTALS	\$190,044.00	\$179,550.00

Robert Webb, ESIS Inc., Subsidiary of Ace Property and Casualty Company

Robert Webb testified before the Grand Jury. Webb is a Claims Supervisor for ESIS Inc., a subsidiary of Ace Property and Casualty Company ("ACE"). Webb testified that ESIS acts as a third party administrator to handle insurance claims for ACE.

ACE received and paid one worker's compensation claim filed by the Pain Center. Webb explained that when a worker's compensation claim is reported to his company, the claim is assigned to a claims adjuster. The claims adjuster has twenty four hours to conduct a three point investigation into the validity of the claim. The worker, the worker's

employer, and the worker's medical provider are contacted by the adjuster. The claims adjuster maintains contact on a daily basis for a month until the investigation is completed. Webb explained that, once an investigation is complete, the claims representative will then determine if a claim is compensable based on their investigation. That determination is made by looking at the following factors: was the injury work related and is the treatment related to the injury sustained in the work related accident.

Webb explained that the worker must receive medical treatment from authorized providers for the first ninety days after a work related injury. After ninety days, the injured worker may treat with any licensed doctor. Webb explained that the claim is usually paid if the treatment given is to the same part of the body that was injured while working. He stated that the only codes usually reviewed on the billings submitted are the diagnostic codes. The diagnostic codes describe the part of the body treated. He stated that the CPT codes are sometimes overlooked if the diagnostic codes match the injury that was deemed compensable.

Webb testified that the Pain Center submitted bills totaling \$5,750 to ESIS for the treatment of their insured patient. ESIS then hired an outside company to negotiate the payment amount with the Pain Center. ACE ended up paying the Pain Center \$4,137.46.

Christopher Sloan, Pennsylvania Manufacturers Association Insurance Company

Christopher Sloan testified before the Grand Jury. Sloan is employed as a Special Investigation Unit coordinator with Pennsylvania Manufacturers Association Insurance Company ("PMA"), a workers compensation insurance company. Sloan's primary

responsibility is to investigate suspicious workers compensation claims referred to him by his staff. He is also responsible for conducting anti-fraud training for other groups of employees and helping his company make sure they are in compliance with state statutes. Depending on the state, there are different yearly state required fraud filings. His company, along with other insurers, are required to let the state know what they are doing to combat insurance fraud.

Sloane explained the claims process. He stated that, once a claim is received by PMA and entered into the claims system, it is usually handled out of their central processing center in Allentown, PA. The claim is issued a claim number and assigned to a worker's compensation supervisor for review. The claim is reviewed by the supervisor and then assigned to a claims adjuster who takes ownership of that file. The claims adjuster then contacts the employer and the injured worker to find out details of the injury and the medical provider to find out what treatments have been rendered and the estimated length of the disability. These things are done in an attempt to determine if the claim is a compensable workers compensation claim. Sloane went on to state that most workers compensation claims received are legitimate and treated as such.

Sloane testified that PMA received one worker's compensation claim that included billings from the Pain Center in the amount of \$160,196. PMA paid the Pain Center \$114.92 of the billed amount. Sloane stated that the claim was rejected as "not related." He explained that this means that PMA determined that the treatment being

provided was not related to the work related injury covered under the workers compensation claim.

Sloane testified that, once a claim is rejected as “not related,” the CPT coding and details of the treatment were most likely not investigated further by PMA. He stated that, to the best of his knowledge, no one from PMA looked at the CPT coding on the invoices submitted by the Pain Center.

Sloan then explained to the Grand Jury his understanding of the elements of insurance fraud. He started by explaining the term “material misrepresentation.” He described this term as meaning a lie told that is directly related to the claim. He then explained that he considers the four elements of proving insurance fraud in his capacity as an investigator for PMA to be as follows:

- Intent or knowledge that you are doing something wrong, this is done on purpose, not a mistake;
- The material misrepresentation;
- Monetary gain, or expected monetary gain; and
- Identification of the perpetrator.

Sloane continued by stating that the billings submitted by the Pain Center never made it to the investigations stage due to the fact that they were denied as being not compensable (the treatment rendered was deemed as not being related to the injury claimed.) Sloane explained that when he looks at claims that are potentially fraudulent, he is focused on the material representation and not the amount of money paid out by PMA.

Kerryanne Holliss, Liberty Mutual Insurance Company

Kerryanne Holliss testified before the Grand Jury. Holliss stated that she is employed by Liberty Mutual Insurance Company ("Liberty Mutual") as a Team Leader. She described her position as managing six employees assigned to the Critical Strategy Unit. She stated that at any given time she is overseeing approximately eight hundred workers compensation claims assigned to her unit. She described the Critical Strategy Unit as managing complex claims, meaning claims where the disability is expected to last more than twenty six weeks or result in greater than \$45,000 in medical billings.

Holliss testified that her unit was assigned a claim involving the Pain Center. She stated that the claim in question was a workers compensation claim arising from a back injury. This claim settled in late 2007. Part of the settlement of the claim allowed open ended medical benefits for one year from the time of settlement. In June 2008, the insured worker began treatment at the Pain Center. In July 2008, Holliss' case agents received a telephone call from the Pain Center asking for authorization of treatment. The case agent initially said that it could not be authorized. The Pain Center responded by offering to see the patient at no charge to Liberty Mutual for the initial evaluation. In August 2008, the injured worker was seen at the Pain Center and diagnosed with lumbar trauma. The Pain Center recommended that the patient undergo RFS once per week for thirteen weeks. Following protocol, Holliss secured a consult with Liberty Mutual's regional medical director, who reviewed the file and decided that the treatment proposed

was not consistent with the medical records. The regional medical director recommended that Liberty Mutual file a utilization review.

Holliss explained that a utilization review in Pennsylvania worker's compensation cases is filed to determine if the treatment requested is reasonable and necessary. She stated that this review is conducted by a doctor assigned by the State of Pennsylvania. She went on to state that a utilization review does not look at CPT coding by the provider. The utilization review only looks at the treatment requested and determines if it is reasonable and necessary. During the utilization review process, the Pain Center performed twenty nine procedures on the insured in less than two months time. The utilization review determined that the treatment suggested by the Pain Center was reasonable and necessary, but it did not address the CPT code. Holliss testified that payment should be made within thirty days, once the utilization review is completed. Holliss testified that Liberty Mutual ended up paying over \$42,000 for these treatments once the utilization review was complete.

Holliss testified that as soon as the utilization was received, a woman named "Kim" from the Pain Center began calling her office "nonstop." According to Holliss, there are Liberty Mutual journal entries stating that "Kim" was hounding and badgering Holliss' employees demanding payment of the bills. In response to those calls, one of Holliss' employees sent an email to the medical review department at Liberty Mutual asking them expedite a review of the Pain Center bills for payment. Holliss testified that the Pain Center bills were then sent to Liberty Mutual's Medical Bill Review

Department. Holliss reviewed the notes from the Medical Bill Review Department regarding the Pain Center bills and stated that, with respect to some of the bills, questions were raised by Liberty Mutual employees concerning the use of CPT code 61790. The notes reflected that an employee of Liberty Mutual concluded that the proper code for the procedure was CPT code 64622, not CPT code 61790. Holliss testified that the employee believed that the Pain Center's procedure description did not support the billing of CPT code 61790. Later bills, using CPT code 61790, were approved for payment by the same employee who had originally questioned the Pain Center's use of CPT code 61790.

Holliss testified that after being contacted by The Philadelphia District Attorney's Office, she emailed the employee that approved the bills for payment. Holliss stated that the employee originally thought that code CPT code 64622 should be used, until she realized that the procedure was not done to a facet nerve. Per Holliss, this same employee mentioned that maybe the unlisted code would be applicable, but ultimately concluded that she didn't know what code should be used. She did not offer Holliss any further explanation as to why she ultimately approved payment for CPT code 61790.

Joseph Lynch, Independence Blue Cross

Joseph Lynch testified before the Grand Jury. Lynch is employed as the manager of Safety and Security at Independence Blue Cross ("IBC") in Philadelphia. Prior to his promotion to his current position, Lynch was a Senior Level Investigator for the Corporate and Financial Investigations Department with IBC. During his tenure as an investigator Lynch was involved in an investigation of the Pain Center. Among

documents Lynch presented to the Grand Jury, were his investigative log and reports documenting contacts with the Pain Center and IBC insured Pain Center patients. Lynch testified that in October of 2004, he was assigned by IBC to investigate a complaint made by a patient insured by IBC. This patient claimed, that after receiving treatment at the Pain Center, he was incorrectly charged a \$1,000 deductible, instead of the \$20 deductible set forth in his plan. Lynch interviewed this patient several times and found that the patient had entered into an agreement with "Kim" from the Pain Center to pay \$1,000 per visit for radiofrequency treatments at the Pain Center. The patient told Lynch that "Kim" told him that insurance usually did not pay for this, but that she would try to get him reimbursements through IBC.

Lynch testified to the grand jury about several other IBC insured patients that went to the Pain Center. One patient told Lynch that Dr. Rogal had given him radiofrequency treatments to his lower back while training Dr. Catherine Maturo to do the procedure. This concerned Lynch due to the fact that Dr. Rogal was a licensed dentist, not a physician. Lynch testified that he also interviewed a second patient that claimed that Dr. Rogal had treated his lower back as well. This second patient also told Lynch that he was charged \$1,000 per visit and was told by the Pain Center staff that they would attempt to bill his insurance to recover the money.

Lynch testified that after speaking to the patients referred to above, he was concerned about the care given and the billings received from the Pain Center. He checked IBC records and found claims from the Pain Center for a total of nine patients

insured by IBC or affiliates of IBC. Lynch then went to the Pain Center in an attempt to review the medical records of the patients insured by IBC. On January 6, 2004, Lynch went to the Pain Center and was met by Kim Rogal. Lynch introduced himself to Kim Rogal and requested to see the medical records of the insured patients. Lynch testified that Kim Rogal became very loud and threatened to sue him. She told him to get out of the office and that he wasn't getting anything. Lynch left his card and told Kim Rogal that he would expect to have the records within thirty days. Lynch stated that he did eventually receive the records.

Lynch explained the issues IBC had with the CPT coding being submitted by the Pain Center on insurance claim forms. Lynch stated that the Pain Center was submitting bills using CPT code 61790, which described a very sophisticated medical procedure that involved cranial surgery. From the patient interviews he conducted, he knew that the Pain Center was not performing cranial surgery. After reviewing the Pain Center billings to IBC using CPT code 61790, Lynch attempted to interview more patients of the Pain Center that were insured by IBC. Lynch stated that while attempting to interview one patient he left a telephone message on the patient's answering machine. The patient returned his call and Lynch scheduled a meeting with the patient for the following day. Approximately one hour later Lynch received a call from someone identifying herself as "Kim" from the Pain Center. This caller told Lynch that he would not be meeting with the patient unless the meeting was conducted at the Pain Center with "Kim" present. Lynch declined this offer, saying that he needed to speak with the insured, but did not

need to speak with “Kim.” The insured patient then got on the line and Lynch explained to the patient that he would like to interview him in relation to claims filed. At that point “Kim” who was still on the line began to get loud and interrupted Lynch’s conversation with the insured patient. “Kim” then told Mr. Lynch that she “represents” the insured patient. When Mr. Lynch asked her if she was an attorney she replied, “No, but I will have my attorney represent him.”

Douglas Babin, State Farm Insurance Company

Douglas Babin testified before the Grand Jury. Babin is a State Farm Insurance Company ("State Farm") employee, currently assigned to their Special Investigation Unit. Babin has been employed by State Farm since 1992.

Babin testified that he became involved in the investigation of the Pain Center after receiving a Grand Jury subpoena for information from the Philadelphia District Attorney’s Office. Babin stated that he found Pain Center billings in the State Farm claims system dating back to 1994. Babin testified that he pulled the claim records for five patients insured by State Farm that had been treated at the Pain Center. Babin stated that for those five patients, the Pain Center billed State Farm a total of \$221,918 and State Farm paid out \$6,369.79.

Babin stated that he found that the Pain Center used CPT code 61790 in all five of the claims. He also found correspondence sent by State Farm to the Pain Center. Babin read the following portion of a letter to the Grand Jury:

Dear Provider, Per your April 22, 2010 phone call, our coding team has again reviewed your billing from 10/31/2007 services performed by Dr. Maturo. They indicate that we've discussed the use of CPT code 61790 previously with you. We have an AMA opinion that supports our assessment that 61790 is not the correct code for the services performed on October 31, 2007. The code is strictly for a gasserian ganglion, which is in the brain and not in the region treated on October 31, 2007.

Babin also provided a document called an "Independent Medical Evaluation Addendum," which pertains to an independent medical review requested by State Farm of the procedures being performed at the Pain Center. This review, according to the documentation, was conducted by Dr. Thomas Costello. After reviewing records of procedures performed by the Pain Center, Dr. Costello writes that, although he does not claim to be an expert in medical coding, he believed that the proper CPT code for the procedures that he reviewed would be 64640.

During Babin's review of State Farm claims involving the Pain Center, he found it odd that the Pain Center had submitted bills using twelve different tax ID numbers. Babin explained that most providers bill using one tax ID number. He stated that usually an individual provider would use their social security number as their tax ID number. In contrast, a group practice would usually form a corporation and have one tax ID number. Moreover, he discovered twenty two more patients, insured by State Farm, that have been treated at the Pain Center. Babin stated that the total billings to State Farm were \$1,153,536 and the total paid out was approximately \$262,000. Babin stated that he was still researching those claims and did not provide documentation related to those claims at the time of his testimony.

Michael Smith, Selective Insurance Company of New Jersey

Michael Smith testified before the Grand Jury. Smith is employed by Selective Insurance Company of New Jersey ("Selective") as an investigator. Smith testified that he became involved in an investigation of the Pain Center that had been started by another investigator from Selective. Smith stated that his role in the investigation consisted of helping to coordinate medical experts. He also assisted the attorney handling the civil case for Selective; contacted other insurance companies; and obtained medical bills and other documents related to this case. Smith stated that Selective had one insured patient that treated at the Pain Center. Selective discovered that the Pain Center was submitting bills for the treatment of this patient using a CPT code that did not fit the procedure that they were performing. Smith went on to state that the Pain Center treated this patient forty eight times, billing \$4,800 for each visit using CPT code 61790. The \$4,800 billed for each visit on CPT code 61790 was among other charges that the Pain Center would bill for each visit. Smith went on to testify that it is Selective's position that if the Pain Center had billed correctly, the bill would have been \$67 rather than \$4,800 for each visit. Smith told the Grand Jury that Selective paid approximately \$57,000 for this claim. Smith testified that the Pain Center sent a precertification request to Selective prior to the treatments. Selective sent this precertification to a physician for review. Smith testified that the physician assigned by Selective to do this review would be best suited to answer questions about the precertification process in this case.

**Dr. David Petro, Consolidated Services Group-
Selective's Precertification Company**

Dr. David Petro testified before the Grand Jury. Dr. Petro is a physician employed by Consolidated Services Group ("CSG") in Hamilton, NJ. Dr. Petro testified that he has been in medical practice for thirty years and has a family practice in Levittown, PA. For the past eleven years, he has worked part time for CSG. Dr. Petro explained that his role at CSG is as a "Physician Adviser" in the Utilization Management Department.

Dr. Petro went on to explain the Personal Injury Protection ("PIP") laws in New Jersey. Dr. Petro stated that the New Jersey PIP law required that an insured individual, who sustained injuries in an auto accident, have all care pre-certified after ten days of treatment before the doctor could render additional care. The insurance company then has the right to either approve or disapprove the precertification request sent in by the doctor. Dr. Petro stated that this process became very burdensome for insurance companies. The insurance companies then began to subcontract this work to companies like CSG. Dr. Petro explained that the patient's doctor was required to send a request to the insurance company for precertification approval and then the insurance company would send that request to a company like CSG. CSG would either certify or not certify the treatment.

In 2004, Dr. Petro was working at CSG, formerly called Alter Services, about three days a week for three to four hours a day reviewing his assigned cases. He estimated that he was reviewing about sixty to eighty cases each day. Dr. Petro testified

that, in accordance with the New Jersey PIP law, he based his decisions on whether the procedures requested are medically necessary.

As an employee of CSG, Dr. Petro testified that he was the physician that reviewed, and ultimately approved the precertification request sent by the Pain Center to Selective. Dr. Petro testified that a precertification request from Selective was received for review by his company on July 27, 2004. The Pain Center requested permission to conduct a procedure called "radiofrequency thermal neurolysis." Office notes and medical information were sent from the Pain Center with their precertification request. Dr. Petro testified that this information was first reviewed by a nurse, which was standard procedure. After the nurse reviewed the precertification request and the paperwork, it was sent to Dr. Petro for review. Some cases received by CSG are approved by the nurses employed by CSG without a review by a physician. The Pain Center case, however, fell into a category that must be approved by a physician based on the guidelines established by CSG. The nurse reviewed the treatment plan submitted by the Pain Center, prepared a summary, and sent the summary to Dr. Petro for his review.

Dr. Petro stated that he approved this procedure after reviewing the paperwork, because he believed that the treatment was medically necessary. Dr. Petro testified that the records he reviewed indicated that this procedure was to be done to the neck of the insured patient and that the injury described in the insurance claim was a neck injury. Dr. Petro stated that he did look at the CPT codes in this case, but at the time in 2004, he did not know what the CPT codes meant. He stated that he had relied on the fact that the

nurses understood the CPT codes. He went on to state that, if he had known at the time that he was approving this procedure as CPT code 61790, which is for radio ablation of the gasserian ganglion, he would have had this claim reviewed by his supervisor.

Dr. Petro told the Grand Jury that back in 2004, even though he was family practitioner, he would review claims involving all medical specialties that came in to his company for review. Since 2004, the review process has changed at CSG. Claims are now reviewed by physicians that practice “like specialties.” For example, a pain management specialist would now review a pain management based request for precertification. Significantly, Dr. Petro stated that, based on his current knowledge of CPT code 61790, he would have disapproved the precertification request for the Pain Center procedure using that CPT code.

Elizabeth Bray, Aetna Insurance Company

Elizabeth Bray testified before the Grand Jury. Bray has been employed by Aetna Insurance Company ("Aetna") for eleven years. She is currently an investigator. Bray testified that Aetna processes approximately five million medical claims a week. She stated that her responsibilities include investigating medical claims from chiropractors, labs and hospitals.

Bray testified that at the request of The Philadelphia District Attorney’s Office she checked Aetna records for claims associated with eight tax identification numbers from Pain Center doctors: Dr. Owen Rogal, Dr. Mitchell Mednick, Dr. Stuart Kauffman, Dr Catherine Maturo, Dr. Paul Palmerio, Dr. Alexander Kiotis, and Dr. Randy Weiss.

Bray testified that a check of those tax identification numbers revealed almost two million dollars in billings. Bray explained that some billings found under these eight tax identification numbers may not be associated with the Pain Center because some of the claims could be from other practices affiliated with the individual physicians.

Bray next testified that she conducted an investigation to determine the amounts billed by the Pain Center using the tax identification numbers provided. Based on her investigation, Bray concluded that the Pain Center billed Aetna a total of \$1,417,122 from 2004 - 2009. Aetna paid the Pain Center \$265,862.73 of the \$1,417,122. Bray explained to the Grand Jury why some of the Pain Center's claims were paid and others were not paid. She explained that Aetna's claims system is automated and most claims are paid by the computer system without review due to the large number of claims processed by Aetna.

In 2004 or 2005, Bray stated that Aetna's Special Investigations Unit opened an investigation into the billing practices of the Pain Center. Aetna placed a "flag" on this provider in their computer system. All claims submitted by the Pain Center were then placed in "pend" status. "Pend" status means that all claims by the Pain Center would be reviewed and additional documentation would be requested from the Pain Center. Bray stated that she believed that the information that caused them to "flag" the Pain Center's claims came from an alert put out by the NICB. Bray testified that the Pain Center's use of CPT code 61790 would not automatically be "flagged" in their system, because there was no valid reason for some providers to use this code. It was not until the notification

from NICB that Aetna began to flag the Pain Center's claims submitted for CPT code 61790.

Anne Browne, Horizon Blue Cross, Blue Shield of New Jersey

Anne Browne testified before the Grand Jury. Browne stated that she is employed by Horizon Blue Cross, Blue Shield of New Jersey ("Horizon") as a Senior Investigator in the Special Investigations Unit. She testified that she is an RN and social worker and she has worked for Horizon for eight years. Prior to working for Horizon, she worked as a healthcare consultant for Price Waterhouse Cooper and other companies.

Browne testified that the Pain Center case was originally referred to the Special Investigations Unit by the Utilization Review Department for investigation because the CPT coding that the Pain Center was using was inappropriate for the procedures that the Pain Center was performing. According to Browne, the Utilization Review Department had unsuccessfully tried to explain to the Pain Center they were using an inappropriate code. Browne stated that she inherited the case from another investigator in 2005.

Browne testified that she reviewed the documentation involved in the Pain Center investigation and found that the Pain Center was using a code, CPT code 61790, that described brain surgery, which had an extremely high value. The Pain Center, however, was billing the brain surgery code for performing procedures on the back, elbows, and knees.

Browne testified that on November 4, 2005, she sent an overpayment demand letter, requesting reimbursement of \$507,358.65, to the Pain Center related to their use of CPT code 61790. Browne read a portion of that letter to the Grand Jury:

Code 61790 does not accurately reflect the procedure described in the operative reports reviewed. The radio frequency surgery procedure should have been billed as an unlisted procedure and submitted for review. Also code 76001 fluoroscopy, physician time more than one hour, assisting a nonradiologic physician. This too misrepresents the services rendered.

Brown received a response to this letter from an attorney representing the Rogals. According to Browne, the letter stated that Horizon was not correct in their description of the procedure and requested to see the peer reviews that Horizon had for this case.

Browne testified that she met with the Rogals' attorney on May 2, 2006, at her office in New Jersey. According to Browne, she provided their attorney with a letter from the AMA at the meeting. The AMA letter was a response to a request for an AMA opinion from Browne regarding the use of CPT code 61790 by the Pain Center⁶. Browne read a portion of that letter from the AMA to the Grand Jury:

The coding example and full procedure report provided were reviewed by the CPT advisors representing the American Academy of Orthopedic Surgeons and The American Orthopedic Association. According to CPT advisors, 'Code 61790 is for intracranial brain procedures. There is no peer reviewed literature that placing a radio frequency probe next to the bone destroys specific neurological structures. This procedure is not performed by many physicians in many locations. Unlisted code 64999 is appropriate'

Browne told their attorney that Horizon would not pay any bills sent by the Pain Center using CPT code 61790. The Rogals' attorney told her that he would review the information and get back to her.

⁶ According to the AMA letter, Browne asked the AMA for clarification for reporting code 61790 versus 64640. The AMA's response stated that code 64999 is the appropriate code.

Browne stated that she sent a letter dated May 24, 2006 to the Rogals' attorney that contained eight peer reviews obtained by Horizon. She explained that peer reviews are done by sending the entire case file, including medical records, to independent physicians to review and offer an opinion. In each of these peer reviews sent to the Rogals' attorney, the reviewing physician agreed that CPT code 61790 was not the appropriate code for the procedures being performed. In addition, the peer reviews stated that the procedure being performed at the Pain Center didn't meet generally accepted standards.

Browne testified that she next heard from the Rogal's attorney via letter in September 2006. Their attorney argued in his letter that CPT code 61790 most closely resembled the procedure being performed at the Pain Center⁷. Browne stated that the letter from the Rogal's attorney did nothing to change Horizon's stance on the billing being submitted by the Pain Center. She stated that it was not appropriate for the Pain Center to be billing CPT code 61790 for the procedure that they were performing.

Browne stated that she put a computer block on billings from the Pain Center by using the doctors' tax identification numbers. Blocking the tax identification numbers was a difficult task due to the multiple numbers that the Pain Center was using to file claims. This means that every claim that came in from the Pain Center was blocked in the computer system and manually reviewed. Browne then explained that CPT code

⁷ The Grand Jury heard testimony from the Rogals' attorneys that they never advised the Rogals to use CPT 61790 and they never advised the Rogals to stop using CPT code 61790. The attorneys simply advocated the Rogals' position. They represented the Rogals from 2001 – 2011.

61790 is an appropriate code when billed legitimately by neurosurgeons. Since the code is a legitimate code, she did not block CPT code 61790 itself. At some point in 2008 the computer block was lifted and Horizon paid out some claims to the Pain Center. Browne testified that she was not sure how the computer block got lifted. As soon as she discovered the payments to the Pain Center, she reinstated the computer block.

Browne stated that CPT code 61790 is not a widely used code. She stated that she researched Horizon files back to the year 2000 to determine the total amount paid to all providers using CPT code 61790. Browne discovered that \$1,117,102.40 was paid to all providers for procedures billed using CPT code 61790, including the The Mayo Clinic, and Cornell. Her review revealed that \$628,240.32, over half the total amount paid by Horizon for CPT code 61790, was paid to the Pain Center.

Browne also found that between 2000 and 2011, the Pain Center billed Horizon \$4,227,728 using CPT code 61790 for approximately forty-four patients. Browne testified that it is Horizon's position that all of the procedures billed under CPT code 61790 by the Pain Center should have been billed using CPT code 64999, an unlisted code. She further stated that use of the unlisted code would have automatically triggered a review by a medical director at Horizon. She believes that, if the claims were filed properly using the unlisted codes, they would have been denied based on the fact that there was no real medical literature that supported the Pain Center procedure.

Dr. Merrill Mirman, Peer Reviewer Relied Upon by Pain Center Attorneys

Dr. Merrill Mirman testified before the Grand Jury. Dr. Mirman stated that he is a physician and surgeon currently in private practice and that he sometimes performs peer reviews. He explained that a peer review is a review of medical records performed on behalf of a third party in order to answer specific questions pertaining to the records. Dr. Mirman charges a fee that is paid by the third party requesting the review.

Dr. Mirman stated that in 2005 he was contracted to perform a peer review of procedures performed by the Pain Center on one patient. Dr. Mirman reviewed the records and wrote a report dated May 4, 2005. Dr. Mirman testified that one of the specific questions posed to him with respect to this case was whether CPT code 61790 was appropriate. In his report, Dr. Mirman stated that the use of CPT code 61790 was appropriate in the patient's case. Dr. Mirman explained to the Grand Jury that he now believes that he mistakenly omitted the word "not" from the answer to that question in his report. Based on medical records and operative reports from the Pain Center's treatment of the patient, Dr. Mirman determined that there was no treatment to the gasserian ganglion and, therefore, the use of CPT code 61790 was not appropriate. Dr. Mirman went on to state that he no longer has notes or records from this peer review and that his only explanation for his report stating that CPT code 61790 was appropriate would be his erroneous omission of the word "not" in that sentence of the report.

ASAC Ronald Kerr, United States Department of Health and Human Services

Assistant Special Agent in Charge (“ASAC”) Ronald Kerr, from the United States Department of Health and Human Services (“HHS”), testified before the Grand Jury.

ASAC Kerr began his career in 1998, as a special agent with HHS, which is charged with investigating Medicare and Medicaid fraud. ASAC Kerr testified that Medicare was set up in the 1960s under the premise that doctors and hospitals are honest and beyond reproach. Medicare processes seven million claims a year and contracts with private insurance companies to pay claims. According to ASAC Kerr, “if there is anyone who is dishonest out there and they’re a provider, they can take advantage of the system.”

ASAC Kerr testified that in 1998 he was part of the Federal Insurance Fraud Task Force and he was assigned to an investigation of the coding practices of the Pain Center that had been started by another agent. He stated that the investigation into the Pain Center started as a criminal investigation, but both criminal and civil attorneys from the United States Attorney’s Office of the Eastern District of Pennsylvania (“USAO”) were assigned to the case. Ultimately, the case was handled exclusively by the civil prosecutor.

ASAC Kerr testified that his investigation began when he received allegations that a dentist was performing a procedure associated with an expensive code: CPT code 61790. His investigation focused on the Pain Center’s use of CPT code 61790 in billings submitted to Medicare. He described the procedure defined by CPT code 61790 as brain surgery that required the use of a “stereotactic machine,” which is a three dimensional x-

ray. ASAC Kerr testified that, at the time of his investigation in the 1990's, there were only a handful of facilities that were performing the procedure defined by CPT code 61790.

ASAC Kerr stated that his investigation revealed that the Pain Center was not performing any procedure that even remotely resembled the procedure defined by CPT code 61790. He based his conclusion on the fact that the procedure being performed at the Pain Center was not complicated and it was not being performed under three dimensional x-ray. He stated that witness' statements indicated that the Pain Center was using a fluoroscope, which is a two dimensional x-ray machine, rather than the three dimensional x-ray required for CPT code 61790.

According to ASAC Kerr, pain management experts repeatedly gave opinions to Medicare that the Pain Center was incorrectly using CPT code 61790 to describe the procedure that they were performing. According to ASAC Kerr, communications from Medicare put the Pain Center on notice that CPT code 61790 was the incorrect code. ASAC Kerr stated that there were cases in which Medicare would deny a Pain Center claim only to have the Pain Center resubmit it under a different doctor's tax identification number in an effort to deceive Medicare. ASAC Kerr stated that, during the investigation, he issued a Medicare fraud alert about the Pain Center, listing the names of approximately 15 doctors that were connected with the Pain Center.

In 2006, the Civil Division of the USAO entered into a settlement agreement with the Pain Center, in which the Pain Center agreed to reimburse the federal government

\$269,528.27 for overpayment by Medicare to the Pain Center. Additionally, the Pain Center agreed to not submit any billing to Medicare for reimbursement for a period of five years from the date of the settlement.

Findings

We find that Dr. Owen Rogal and Kim Rogal used a legitimate business, the Pain Center, to systematically defraud insurance companies by knowingly submitting falsified health claims. Dr. Rogal and Kim Rogal continued to bill CPT code 61790, a complex and expensive brain surgery, despite being repeatedly reprimanded by Medicare, private insurance companies, the AMA, the federal government and peer reviewers because the code was incorrect, substantially inflating the price of the procedure performed.

We believe that the Rogals defrauded insurance companies by filing claims in a manner that would hide their behavior. As insurance representatives testified, because of the large number of claims filed daily and the premise that doctors are honest, claims are often automatically paid without review. Moreover, we heard from representatives that when workers compensation claims are reviewed, the reviewers focused on whether the part of the body being treated by the Pain Center was the same part of the body injured on the job. Therefore, many insurance companies would approve a worker's compensation claim, if it was medically necessary, without checking the accuracy of the CPT coding. Finally, the representatives testified that it was harder to monitor the fraudulent claims due to the Rogals filing claims using multiple doctors' tax identification numbers.

We find no merit in the arguments advanced by Dr. Rogal, Kim Rogal, and their attorneys, including the "semi-colon" argument. It is clear to us, based on witnesses' testimony and the CPT Codebook, that a provider can't approximate a CPT code and that a provider can't ignore the language after a semi-colon. CPT code 61790 is a procedure performed on the gasserian ganglion in the brain. By ignoring the gasserian ganglion language after the semi-colon, the Pain Center and its' attorneys blatantly ignored the fact that the part of the body treated has a significant impact on the value of CPT code 61790. Surgery on the gasserian ganglion requires more physician work effort, practice expense, and malpractice expense and, therefore, would be valued at a higher dollar amount than the Pain Center procedure. In contrast, witnesses, including current and former Pain Center doctors, testified that the Pain Center procedure was neither complicated nor a high risk procedure. We find that the Pain Center procedure is not equivalent in complexity or value to brain surgery performed by a neurosurgeon.

We find that the AMA and insurance companies place a higher monetary value on brain surgery than on the Pain Center procedure. Witnesses described the difference in payment for the procedure defined by CPT code 61790 and the actual procedure being performed at the Pain Center by doctors employed by the Rogals. The Rogals charged approximately \$4800 per visit/ per patient, using CPT code 61790 for the Pain Center procedure. We find that, if the Rogals had been billing the correct code for the procedure they were actually performing, they would have charged approximately \$800.

Additionally, we find that the Rogals charged inappropriately for several other CPT codes.

We find that insurance companies and the federal government repeatedly told the Rogals that they should bill a CPT code in the 64000 series that accurately reflected the value and complexity of the procedure being performed. We believe that the Pain Center chose not to bill in the 64000 series, even after it was told time and time again, because it would pay significantly less money. Moreover, the Rogals chose not to use the unlisted code (CPT 64999), as recommended by the AMA and others, because an unlisted codes would automatically trigger a review of the claim by the insurance company.

We find that Dr. Owen Rogal and Kim Rogal were aware that CPT 61790 was incorrect and improper, based on significant amounts of communications and meetings over the years. We further find that their continued pattern of racketeering by filing fraudulent medical claims was for monetary gain.

Conclusion

We, the Grand Jury, believe that the following criminal acts arise out of the conduct of Dr. Owen Rogal and Kim Rogal (a/k/a Kim DeOliveira):

Dr. Owen Rogal

Corrupt Organizations, 18 Pa.C.S.A. §911 (1 count) (F1)
Criminal Conspiracy, 18 Pa.C.S.A. §903 (1 count) (F1)
Insurance Fraud, 18 Pa.C.S.A. §4117 (15 counts) (F3)
Theft by Deception, 18 Pa.C.S.A. §3922 (12 counts) (F3)
Attempted Theft by Deception, 18 Pa.C.S.A. §3922 (10 counts) (F3)

Kim Rogal (a/k/a Kim DeOliveira)

Corrupt Organizations, 18 Pa.C.S.A. §911 (1 count) (F1)

Criminal Conspiracy, 18 Pa.C.S.A. §903 (1 count) (F1)

Insurance Fraud, 18 Pa.C.S.A. §4117 (15 counts) (F3)

Theft by Deception, 18 Pa.C.S.A. §3922 (12 counts) (F3)

Attempted Theft by Deception, 18 Pa.C.S.A. §3922 (10 counts) (F3)

We, Philadelphia County Investigating Grand Jury XXIV, therefore recommend that based upon all the evidence presented to us, the criminal complaint specified above in this presentment be filed by the Philadelphia District Attorney's Office.