IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

(1) UNITED STATES OF AMERICA, *ex rel.* UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,	)	
(2) STATE OF OKLAHOMA,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	**Case No. 14-CV-431-CVE-TLW**
	)	
(1) ROBERT CHARLES DUKE, O.D.,	)	
(2) VISION & EYE MEDICAL DIAGNOSTIC AND LASER CENTER, INC.,	)	
	)	
Defendants.	)	

COMPLAINT

Plaintiffs, the United States of America *ex rel*. United States Department of Health and Human Services ("United States"), by and through Danny C. Williams, Sr., United States Attorney for the Northern District of Oklahoma, and Assistant United States Attorney, Ryan L. Souders, and the State of Oklahoma ("State"), by Niki S. Batt, Assistant Attorney General, for their Complaint against Robert Charles Duke, O.D. and Vision & Eye Medical Diagnostic and Laser Center, Inc., ("Defendants") allege as follows:

INTRODUCTION

This action arises from the conduct of the defendants in making false claims by presenting false and inflated bills to the United States and the State of Oklahoma for services purportedly rendered to Medicare and Medicaid beneficiaries between January 1, 2005, and the present.

JURISDICTION, VENUE AND THE PARTIES

1. The United States brings this action on behalf of the United States Department of Health and Human Services, a federal agency, pursuant to 31 U.S.C. §§ 3729 *et seq*. (False Claims Act) and under the common law for unjust enrichment and breach of contract.

2. The State of Oklahoma brings this action under the Oklahoma Medicaid False Claims Act, 63 OKLA. STAT. tit. §§ 5053 *et seq*., and the common law for unjust enrichment and breach of contract.

3. Jurisdiction is conferred upon this Court pursuant to 28 U.S.C. §1345, 31 U.S.C. §§ 3732(a) and (b), and 28 U.S.C. § 1367(a).

4. A substantial part of the events giving rise to the claims described herein occurred within the Northern District of Oklahoma. 28 U.S.C. § 1391.

5. The United States Department of Health and Human Services administers the Medicare Program for eligible United States citizens.

6. The Oklahoma Health Care Authority administers the Medicaid Program for eligible lower income citizens of the State.

7. The Medicare Program is funded by the United States, while the Medicaid Program is funded by both the United States and the State of Oklahoma.

8. Defendant Robert Charles Duke, O.D., is a duly licensed optometrist in the State of Oklahoma and the owner of Defendant Vision & Eye Medical Diagnostic and Laser Center, Inc., which is located at 2310 North Highway 66, Catoosa, Oklahoma. The acts complained of herein occurred at the defendants' office or at several nursing homes including Parks Edge Nursing & Rehabilitation, Green Country Care Center and Tulsa Nursing Center and involve

claims for payment made by the defendants to the United States and the State under the Medicare and Medicaid Programs.

9. Plaintiffs and Defendants are parties to a written Tolling Agreement that extended the Statute of Limitations for the plaintiffs to bring this action until August 1, 2014.

COUNT I
VIOLATIONS OF THE FALSE CLAIMS ACT, 31 U.S.C. §§ 3729 *et seq.*

10. Plaintiff, the United States, brings this count and adopts and incorporates by reference the allegations set forth in paragraphs 1 through 9 above as though set forth in full at this place.

11. At all times herein mentioned, Defendants were "approved providers" with the Medicare Program and were under contract to provide medical services to Medicare participants.

12. Medicare's 1997 Documentation Guidelines for Evaluation and Management Services ("DG"), which are the guidelines applicable at all times pertinent, set forth the nature and extent of the physician's work, necessary documentation and the time required to be spent by the physician "face-to-face" with the patient in order to bill using the appropriate Evaluation and Management billing codes, also known as Current Procedural Terminology ("CPT") codes. The DG specifically state that complete medical record documentation is required as a prerequisite for payment and must include the reason for the visit, relevant history, physical examination findings and diagnostic test results; assessment, clinical impression or diagnosis; plan for care, time spent with the patient and the date and identity of the observer, among other things.

13. CPT codes are used to submit bills to Medicare for the various medical services provided and the time spent with the patient.

14. In order for the physician to bill CPT code 99205, the DG require detailed documentation with respect to each of the following three components: a comprehensive history,

a comprehensive examination, medical decision making of high complexity and typically 60 minutes "face-to face" with the patient.

15. In order for the physician to bill CPT code 99215, the DG require detailed documentation with respect to at least two of the following key components: a comprehensive history, a comprehensive examination, medical decision making of high complexity and typically 45 minutes "face-to face" with the patient.

16. The DG require that a comprehensive history include detailed documentation of the following elements: extended history of present illness, complete review of symptoms and complete review of past family and/or social history.

17. The DG require that a comprehensive examination include detailed documentation of a general multi-system examination or a complete examination of a single organ system and other symptomatic or related body areas(s) or organ system(s).

18. The DG require that a comprehensive general multi-system examination of the eyes include detailed documentation of: inspection of conjunctivae and lids, examination of pupils and irises (e.g., reaction to light, and accommodation, size and symmetry), and ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages).

19. The DG require that a comprehensive examination of a single organ system with respect to the eyes include detailed documentation of all of the following elements: test visual acuity (does not include determination of refractive error); gross visual field testing by confrontation; test ocular motility including primary gaze alignment; inspection of bulbar and palpebral conjunctivea; examination of ocular adnexae including lids (e.g., ptosis or lagophthalmosis), lacrimal glands, lacrimal drainage, orbits and preaurical lymph nodes;

examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size, (e.g., anisocoria) and morphology; slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film; slit lamp examination of the anterior chambers including depth, cells, and flare; slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus; measurement of interocular pressures (except in children and patients with trauma or infectious disease); ophthalmoscoic examination through dilated pupils (unless contraindicated) of optic discs including size, C/D ratio, appearance (e.g., atrophy, cupping, tumor evaluation) and nerve fiber layer, posterior segments including retina and vessels, (e.g., exudates and hemorraghes).

20. The DG require that in order to qualify as a medical decision of high complexity, detailed documentation provided by the physician must indicate that two of the following three elements were met or exceeded: the number of diagnosis or management options must be extensive, the amount and/or complexity of data to be reviewed must be extensive, and/or the risk of complications and/or morbidity or mortality must be high.

21. Between January 1, 2005, and the present, the documentation in support of the bills submitted by Defendants to Medicare under CPT codes 99205 and 99215 did not comply with Medicare regulations in that, among other things, it did not reflect that a comprehensive history was taken, a comprehensive examination was made and that defendants undertook medical decision making of high complexity, as defined in paragraphs 12 through 20, above. Further, the documentation did not reflect that the defendants spent “face-to-face” time of 45 and 60 minutes, respectively, with the patients as set forth in paragraphs 14 and 15, above.

22. Between January 1, 2005, and the present, Defendants also submitted bills to Medicare under CPT code 99212 that requires documentation demonstrating that at least two of

the following three key components were met: a problem focused history (brief history of present illness), a problem focused examination (one to five of the elements set forth in paragraph 19 were performed) and straightforward medical decision making (two of the following three elements were met or exceeded: the number of diagnosis or management options must be minimal, the amount and/or complexity of data to be reviewed must be minimal or none, and the risk of complications and/or morbidity or mortality must be minimal). Usually the physician spends 10 minutes "face-to-face" with the patient or family. The bills submitted by Defendants to Medicare under CPT code 99212 did not comply with Medicare regulations in that the documentation was incomplete or insufficient and did not demonstrate that the required amount of time was spent with the patient.

23. Between January 1, 2005, and the present, Defendants also submitted bills to Medicare under CPT code 99213 that requires documentation demonstrating that at least two of the following three key components were met: an expanded problem focused history (brief history of present illness and problem pertinent review of symptoms), a problem focused examination (one to five of the elements set forth in paragraph 19 were performed) and straightforward medical decision making (two of the following three elements were met or exceeded: the number of diagnosis or management options must be minimal, the amount and/or complexity of data to be reviewed must be minimal or none, and the risk of complications and/or morbidity or mortality must be minimal). Usually the physician spends 15 minutes "face-to-face" with the patient or family. The bills submitted by defendants to Medicare under CPT code 99213 did not comply with Medicare regulations in that the documentation was incomplete or insufficient and did not demonstrate that the required amount of time was spent with the patient.

24. Between January 1, 2005, and the present, Defendants also submitted bills to Medicare under CPT code 99214 that requires documentation demonstrating that at least two of the following three key components were met: a detailed history (extended history of present illness, extended review of symptoms and pertinent past, and family and/or social history), a detailed examination (at least nine of the elements set forth in paragraph 19 were performed) and medical decision making of moderate complexity (two of the following three elements were met or exceeded: multiple number of diagnosis or management options, moderate amount and/or complexity of data to be reviewed, and high risk of complications and/or morbidity or mortality). Usually the physician spends 25 minutes "face-to-face" with the patient or family. The bills submitted by defendants to Medicare under CPT code 99214 did not comply with Medicare regulations in that the documentation was incomplete and insufficient and did not demonstrate that the required amount of time was spent with the patient.

25. During 2006 through early 2010, Defendants billed Medicare in excess of 12 hours per day on 387 occasions; 124 of those occasions were in excess of 24 hours per day; and, in one instance, Defendants billed for 68 hours for one day, a further indication, in addition to incomplete, and insufficient medical records as alleged above, that Defendants did not provide the required medical services and did not spend the "face-to-face" time required in order to justify billing under CPT codes 99205, 99215, 99212, 99213, 99214,76514, 92020, 92225, 92083, 92135, 68761, 68801, 92250, 99245, 99211, 99212, 92012, 92226, A4263, 92135, 92100, V2100, V2213 and A4262, among others, all to the damage of the United States in the sum of $846,967.00.

26. Four hundred and twenty-two times during the years 2005, 2006 and 2007 (152 times during the year 2005, 180 times during 2006, and 90 times during 2007), Defendants

submitted bills using a place of service code that indicated that medical services were provided at Defendants' office, at a higher rate of payment, when, in fact, the services were rendered at nursing homes and should have been billed under a different place of service code at a lower rate of payment, all to the actual damage of the United States in the sum of $76,803.00.

27. The total amount of false and inflated bills that were submitted by Defendants and paid by Medicare and the total amount of actual damages sustained by the United States as a result of Defendants' false claims are in the amount of $923,770.00.

28. Defendants knew, or should have known, that they were not keeping accurate, sufficient and complete records concerning the medical services they were providing to justify their billing; knew or should have known, that they were billing for services that were rendered at their office when the services were actually being provided at nursing homes; and knew, or should have known, that they were submitting inaccurate, incomplete, insufficient and false billing codes indicating that more services were provided and more time was spent in the care and treatment of Medicare recipients than actually provided, all of which were in violation of the False Claims Act and resulted in false, erroneous and inflated bills being submitted to and paid by the United States.

29. Each bill submitted by Defendants based upon incomplete, inaccurate or erroneous records and documentation; each bill submitted for services provided at Defendants' office that were actually provided at a nursing home; each bill submitted containing an inaccurate or false billing code; and each bill submitted where services claimed were not provided, including those in excess of 12 hours per day, constituted a false claim in violation of the False Claims Act and a separate count for purposes of this Complaint.

30. Pursuant to the False Claims Act, Defendants are liable to the United States for civil penalties of not less than $5,500.00 and not more than $11,000.00 for each false claim plus three times the amount of actual damages which the United States sustained as a result of Defendants' false claims.

COUNT II
BREACH OF CONTRACT

31. Plaintiff, the United States, brings this count and adopts and incorporates by reference the allegations set forth in paragraphs 1 through 30 above as though set forth in full at this place.

32. At all times herein mentioned, Defendants were parties to a written contract with the United States whereby Defendants were approved and authorized to provide medical care and treatment to Medicare recipients in compliance with Medicare rules and regulations in exchange for payment by the United States.

33. The United States has complied with all obligations required of it under the terms and conditions of the contract.

34. Between January 1, 2005, and the present, Defendants failed to comply with Medicare rules and regulations and breached said contract in the following respects, among others:

A. Failing to keep complete, detailed and accurate patient medical records reflecting that the necessary services were provided and that the required time was spent to justify the bills submitted to and paid by the United States.

B. Submitting inaccurate and false billing statements to the United States on 422 occasions indicating that Defendants provided the medical care and treatment to Medicare recipients at the Defendants' office when the services were actually

provided at nursing homes which resulted in erroneous and inflated bills being submitted to and paid by the United States.

C. Submitting inaccurate and false CPT codes indicating that more services were provided and more time was spent in the care and treatment of Medicare beneficiaries than was actually provided which resulted in erroneous and inflated bills being submitted to and paid by the United States.

D. Claiming that services were provided in excess of 12 hours per day on 387 occasions, in one instance claiming that Defendants provided 68 hours of services in one day, when the services claimed were not delivered.

35. The total amount of false and inflated bills that were submitted by Defendants and paid by the United States and the actual damages sustained by the United States as a direct and proximate result of Defendants' breach of contract are in the total amount of $923,770.00.

COUNT III
UNJUST ENRICHMENT

36. Plaintiff, the United States, brings this count and adopts and incorporates by reference the allegations set forth in paragraphs 1 through 35 above as though set forth in full at this place.

37. As a direct and proximate result of the acts and omissions of the defendants, as hereinbefore alleged, the United States has paid monies to the defendants that they were not entitled to receive in the total amount of $923,770.00.

38. Defendants have therefore been unjustly enriched, and the United States has been damaged in the total amount of $923,770.00.

39. The United States is entitled to restitution for the full amount of the payments made to Defendants, to which they were not entitled, to the sum of $923,770.00.

COUNT IV
VIOLATIONS OF THE OKLAHOMA MEDICAID FALSE CLAIMS ACT

40. Plaintiff, the State of Oklahoma, brings this count and adopts and incorporates by reference the allegations set forth in paragraphs 1 through 39 above as though set forth in full at this place.

41. At all times herein mentioned, Defendants were "approved providers" with the Medicaid Program and were under contract to provide medical services to Medicaid recipients in the State of Oklahoma.

42. The Medicaid Guidelines of the State of Oklahoma are the same as the Federal Medicare Guidelines, set forth above in paragraphs 12 through 20, and the allegations in paragraphs 12 through 20 are incorporated by reference with respect to the State of Oklahoma and the Medicaid Program.

43. During 2008 through 2010, Defendants billed Medicaid in excess of 12 hours per day on 96 occasions, a further indication, in addition to incomplete and insufficient patient medical records as hereinbefore alleged, that Defendants did not provide the required medical services and did not spend the "face-to-face" time required in order to justify billing under CPT codes 99205, 99215, 99212, 99213, 99214,76514, 92020, 92225, 92083, 92135, 68761, 68801, 92250, 99245, 99211, 99212, 92012, 92226, A4263, 92135, 92100, V2100, V2213 and A4262, among others, all to the actual damage of the State of Oklahoma in the sum of $151,739.51.

44. Defendants knew, or should have known, that they were not keeping accurate, sufficient and complete patient records concerning the medical services they were purportedly providing to justify their billing and that they were submitting inaccurate and false billing codes indicating that more services were provided and more time was spent in the care and treatment of

Medicaid recipients than was actually provided, all of which resulted in false, erroneous and inflated bills being submitted to and paid by the State of Oklahoma.

45. In 2007, the State of Oklahoma enacted 63 OKLA. STAT. tit. §§ 5053 *et seq.*, known as the Oklahoma Medicaid False Claims Act ("OMFCA"), which became effective on November 1, 2007. The OMFCA provides for civil monetary penalties of not less than $5,000.00 and not more than $10,000.00 for each false claim plus three times the amount of the actual damages sustained by the State of Oklahoma as a result of each false claim.

46. Each bill submitted by Defendants in 2008, 2009 and 2010 based upon incomplete, inaccurate or erroneous records and documentation; each bill submitted containing an inaccurate or false billing code; each bill submitted claiming services were provided in excess of what was actually provided, including those in excess of 12 hours per day, constituted a false claim in violation of the OMFCA and is a separate count for purposes of this Complaint. Pursuant to the OMFCA, Defendants are liable to the State for civil penalties of not less than $5,000.00 and not more than $10,000.00 for each false claim plus three times the amount of actual damages which the State sustained.

COUNT V
BREACH OF CONTRACT

47. Plaintiff, the State of Oklahoma, brings this count and adopts and incorporates by reference the allegations set forth in paragraphs 1 through 46 above as though set forth in full at this place.

48. At all times herein mentioned, Defendants were "approved providers" with the Medicaid Program and parties to a written contract with the State whereby Defendants were authorized to provide medical care and treatment to Medicaid recipients in compliance with the

Medicaid rules and regulations of the Oklahoma Health Care Authority in exchange for payment by the State.

49. The State has complied with all obligations required of it under the terms and conditions of the contract.

50. Between January 1, 2005, and the present, Defendants submitted bills to Medicaid under the following CPT codes: 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99324 and 99335 for services purportedly rendered to Medicaid beneficiaries. Medicaid's Guidelines set forth the nature and amount of physician work and documentation required and the time required to be spent "face-to-face" with the patient in order for physicians to bill using the appropriate CPT codes. The requirements with respect to the type of history, examination, medical decision making and time spent "face-to-face" with the patient in order to bill under CPT codes 99213, 99214, 99215 99304, 99305, 99306, 99307, 99308, 99309, 99324 and 99335 are defined in paragraphs 12 through 20 above.

51. Between January 1, 2005, and the present, Defendants failed to comply with Medicaid rules and regulations and breached said contract in the following respects, among others:

A. Failing to keep complete, detailed and accurate patient records reflecting that the required services were provided and that the required time was spent to justify the bills submitted to and paid by the State.

B. Submitting inaccurate and false CPT codes indicating that more services were provided and more time was spent in the care and treatment of Medicaid beneficiaries than was actually provided which resulted in erroneous and inflated bills being submitted to and paid by the State.

C. Claiming that services were provided in excess of 12 hours per day on 96 occasions when the services claimed were not delivered.

52. As a direct and proximate result of the acts and omissions of the Defendants and their breach of contract, the State has suffered actual damages in the amount of $268,222.85.

COUNT VI
UNJUST ENRICHMENT

53. Plaintiff, the State of Oklahoma, brings this count and adopts and incorporates by reference the allegations set forth in paragraphs 1 through 52 above as though set forth in full at this place.

54. As a direct and proximate result of the acts and omissions of the defendants, as hereinbefore alleged, the State has paid monies to the defendants under the Medicaid Program that they were not entitled to receive in the amount of $268,222.85.

55. Defendants have therefore been unjustly enriched, and the State has been damaged, in the amount of $268,222.85.

56. The State of Oklahoma is entitled to restitution for the full amount of the payments made to Defendants to which they were not entitled, in the amount of $268,222.85.

WHEREFORE, the United States and the State of Oklahoma pray that judgment be entered against both Defendants, jointly and severally, as follows:

UNDER COUNT I
VIOLATIONS OF THE FALSE CLAIMS ACT

1. For the sum of $2,771,310.00 which is three times the actual damages sustained by the United States, pursuant to the False Claims Act;

2. For a penalty of between $5,500.00 and $11,000.00 per each of the 809 false claims, pursuant to the False Claims Act;

3. For the costs of suit incurred herein;

4. For all interest allowed by law; and

5. For such other and further relief as the Court deems just and proper.

UNDER COUNT II
BREACH OF CONTRACT

1. For damages sustained by the United States as a result of Defendants' breach of contract in the amount of $923,770.00;

2. For the costs of suit incurred herein;

3. For all interest allowed by law; and

4. For such other and further relief as the Court deems just and proper.

UNDER COUNT III
UNJUST ENRICHMENT

1. For the sum of $923,770.00, the amount by which the defendants were unjustly enriched and the United States was damaged;

2. For the costs of suit incurred herein;

3. For all interest allowed by law; and

4. For such other and further relief as the Court deems just and proper.

UNDER COUNT IV
VIOLATIONS OF THE OKLAHOMA MEDICAID FALSE CLAIMS ACT

1. For the sum of $455,218.53 which is three times the actual damages sustained by the State of Oklahoma, during 2008, 2009 and 2010, pursuant to the Oklahoma Medicaid False Claims Act;

2. For a penalty of between $5,000.00 and $10,000.00 per each of the 96 false claims made during 2008, 2009 and 2010, pursuant to the Oklahoma Medicaid False Claims Act;

3. For the costs of suit incurred herein;

4. For all interest allowed by law; and

5. For such other and further relief as the Court deems just and proper.

UNDER COUNT V
BREACH OF CONTRACT

1. For breach of contract damages sustained by the State of Oklahoma in the amount of $268,222.85;

2. For the costs of suit incurred herein;

3. For all interest allowed by law; and

4. For such other and further relief as the Court deems just and proper.

UNDER COUNT VI
UNJUST ENRICHMENT

1. For the sum of $268,222.85, the amount by which the defendants were unjustly enriched and the State of Oklahoma was damaged;

2. For the costs of suit incurred herein;

3. For all interest allowed by law; and

4. For such other and further relief as the Court deems just and proper

Dated July 28, 2014.

Respectfully Submitted,

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