UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF INDIANA
HAMMOND DIVISION

UNITED STATES OF AMERICA and STATE OF INDIANA **Plaintiffs,** **v.** **DON J. WAGONER, MARILYN L. WAGONER, WAGONER MEDICAL CENTER, L.L.C., WAGONER MEDICAL CENTER, P.C., AND DON J. WAGONER, M.D. AND MARILYN L. WAGONER, M.D., P.C.** **Defendants.**	)	**Case No. 2:17CV478**

COMPLAINT AND JURY DEMAND OF PLAINTIFFS UNITED STATES OF AMERICA AND STATE OF INDIANA

INTRODUCTION

1. Plaintiff United States of America (United States) brings this action against defendants pursuant to the False Claims Act, 31 U.S.C. §§ 3729-3733 (FCA), seeking treble damages and civil penalties, and also seeking damages under common law for overpayments from the Indiana Medicaid Program induced by defendants' false and fraudulent billings for medical services. Plaintiff State of Indiana (Indiana) joins in this Complaint against defendants pursuant to the Indiana Medicaid False Claims and Whistleblower Protection Act, Ind. Code § 5-11-5.7, seeking treble damages and civil penalties, and also seeking damages under common law for overpayments from the Indiana Medicaid Program induced by defendants' false and fraudulent billings for medical services.

JURISDICTION AND VENUE

2. This Court has jurisdiction over this FCA action pursuant to 31 U.S.C. § 3732(a). Additionally, 31 U.S.C. § 3732(b) specifically confers jurisdiction on this Court over the state law claims in this Complaint because the state law claims arise from the same acts on which the United States has filed suit under the FCA.

3. This Court may exercise personal jurisdiction over defendants because all defendants reside, and transacted business that gave rise to plaintiffs' claims, in this district.

4. Venue is proper within the Northern District of Indiana pursuant to 28 U.S.C. § 1391 because defendants reside, and transacted business that gave rise to plaintiffs' claims, in this district.

PARTIES

5. Plaintiff United States of America brings this action on behalf of itself and the United States Department of Health and Human Services (HHS), an agency of the United States. HHS' Secretary oversees the Medicaid Program through one of HHS' divisions, the Centers for Medicare and Medicaid Services (CMS). Funding for Medicaid is shared between the federal government and those states, including Indiana, participating in the Medicaid Program.

6. Plaintiff State of Indiana brings this action on behalf of itself and the Office of Medicaid Policy and Planning, a division of the Indiana Family and Social Services Administration, which administers the Indiana Health Coverage Program (IHCP or Indiana Medicaid).

7. Defendant Don J. Wagoner is the owner and registered agent of defendants Wagoner Medical Center, L.L.C., Wagoner Medical Center, P.C., and Don J. Wagoner, MD and

Marilyn L. Wagoner, MD, PC. During all times relevant to this Complaint, Don Wagoner practiced medicine through these entities.

8. Defendant Marilyn L. Wagoner is the spouse of Don J. Wagoner. She is also the co-owner of Don J. Wagoner, M.D. and Marilyn L. Wagoner, M.D., P.C. and an executive of Wagoner Medical Center, P.C. During all times relevant to this Complaint, Marilyn Wagoner practiced medicine through these entities. During all times relevant to this Complaint, Marilyn Wagoner also practiced medicine at Wagoner Medical Center, L.L.C.

9. Defendant Wagoner Medical Center, L.L.C. was organized as a medical facility by Don J. Wagoner, who is its owner and registered agent. During all times relevant to this Complaint, Wagoner Medical Center, L.L.C. was registered as a Medicaid provider and authorized biller with the Indiana Medicaid Program.

10. Defendant Wagoner Medical Center, P.C. was organized as a medical facility by Don J. Wagoner, who is its owner and registered agent. During all times relevant to this Complaint, defendants Don J. Wagoner and Marilyn L. Wagoner practiced medicine through this entity.

11. Defendant Don J. Wagoner, M.D. and Marilyn L. Wagoner, M.D., P.C. (Wagoner PC) was organized as an Indiana Medical Professional Corporation by Don J. Wagoner and Marilyn L. Wagoner. During all times relevant to this Complaint, Wagoner PC and its shareholders, officers, and agents rendered medical services through this entity.

STATUTORY AND REGULATORY FRAMEWORK

A. Federal False Claims Act

12. The FCA prohibits knowingly presenting, or causing to be presented a false or fraudulent claim for payment or approval of federal funds. 31 U.S.C. § 3729(a)(1)(A).

13. The FCA prohibits knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim. 31 U.S.C. § 3729(a)(1)(B).

14. The FCA prohibits knowingly concealing or improperly avoiding or decreasing an obligation to pay or transmit federal funds. 31 U.S.C. § 3729(a)(1)(G).

15. For purposes of the FCA the term "knowingly mean[s] that a person has actual knowledge of the information; acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information; and requires no proof of specific intent to defraud[.]" 31 U.S.C. § 3729(b)(1).

16. The FCA prohibits a conspiracy to commit violations of the FCA described in paragraphs 12, 13, and 14 of this Complaint. 31 U.S.C. § 3729(a)(1)(C).

17. The FCA provides that defendants who commit violations of the FCA described in paragraphs 12, 13, 14, and 16 of this Complaint are liable to the United States Government for "3 times the amount of damages which the Government sustains because of the act of that person" and for a civil penalty of not less than $5,500 and not more than $11,000 per false claim and the costs of this civil action brought to recover any such penalty or damages. 31 U.S.C. § 3729(a)(1), (3); Federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. 2461 note; Public Law 101-410; 64 Fed. Reg. 47,099, 47,103 (1999).

B. Indiana Medicaid False Claims and Whistleblower Protection Act

18. The Indiana Medicaid False Claims and Whistleblower Protection Act (INFCA) prohibits knowingly presenting, or causing to be presented a false or fraudulent claim for payment or approval of state funds. Ind. Code § 5-11-5.7-2(a)(1).

19. The INFCA prohibits knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim. Ind. Code § 5-11-5.7-2(a)(2).

20. The INFCA prohibits knowingly concealing or improperly avoiding or decreasing an obligation to pay or transmit federal funds. Ind. Code § 5-11-5.7-2(a)(6)(B).

21. For purposes of the INFCA the term "knowingly mean[s] that a person has actual knowledge of the information; acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information; and requires no proof of specific intent to defraud[.]" Ind. Code § 5-11-5.7-1(a)(4).

22. The INFCA prohibits a conspiracy to commit violations of the INFCA described in paragraphs 18, 19, and 20 of this Complaint. Ind. Code § 5-11-5.7-2(a)(7).

23. The INFCA provides that defendants who commit violations of the INFCA described in paragraphs 18, 19, 20, and 22 of this Complaint are liable for "3 times the amount of damages which the Government sustains because of the act of that person" and for a civil penalty of not less than $5,500 and not more than $11,000 per false claim and the costs of a civil action brought to recover any such penalty or damages. Ind. Code § 5-11-5.7-2(a); Federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. 2461 note; Public Law 101-410; 64 Fed. Reg. 47,099, 47,103 (1999).

C. Medicaid Program Overview

24. In 1965, Congress established the Medicaid program under Title XIX of the Social Security Act, 42 U.S.C. §1396-1396w-2 (Medicaid Program). The Medicaid Program provides medical and health-related assistance for society's neediest and most vulnerable individuals.

25. Medicaid is a state-administered program and each state sets its own guidelines regarding eligibility and services, but the states and the United States jointly fund Medicaid. *See* 42 U.S.C. § 1396b.

26. The federal portion of a state's Medicaid payments, known as the Federal Medical Assistance Percentage (FMAP), is based on the state's per capita income compared to the national average. 42 U.S.C. § 1396d(b). The FMAP varies from state to state, from approximately 50% to 83%.

27. To receive federal funds, each state must submit a plan that complies with federal requirements. *See* 42 U.S.C. § 1396a.

28. HHS, through one of its divisions, CMS, formerly known as the Health Care Financing Administration, oversees the Medicaid Program, promulgates rules and regulations for all participants, and monitors the states' compliance with these rules and regulations.

D. Indiana Medicaid Program

29. The State of Indiana implements its Medicaid program pursuant to a state plan approved under Title XIX of the Social Security Act, which implements federal and state statutes and regulations.

30. Medicaid in the State of Indiana is called the Indiana Health Coverage Program (IHCP or Indiana Medicaid), and is administered by the Office of Medicaid Policy and Planning, a division of the Indiana Family and Social Services Administration (FSSA).

31. Within broad federal rules, Indiana Medicaid decides eligibility, the services covered, payment levels for services, and administrative and operational procedures. Indiana Medicaid directly pays providers, and obtains the federal share of the payment from the United States Treasury funds.

32. During all times relevant to this Complaint, the United States provided funds to the State of Indiana through the Medicaid Program.

33. Enrolled medical service providers for Medicaid patients in the State of Indiana are eligible for reimbursement for covered services under the provisions of the Social Security Act and of the State of Indiana Medicaid statute, Indiana Code § 12-15, *et seq*.

34. Under Indiana Code § 12-15-1-10, the Indiana Secretary of the FSSA may adopt rules to implement the Medicaid program. Pursuant to this authority, the Secretary has promulgated rules to require compliance by all enrolled providers with Medicaid program provisions.

35. Under Indiana Code § 12-15-11-2, medical providers who wish to provide services to Medicaid patients must execute a Provider Agreement.

36. Under the Provider Agreement, a provider, together with its authorized agents, employees and contractors, are required to comply with all federal and State of Indiana statutes and regulations pertaining to Medicaid, the IHCP Provider Manual, and all bulletins and notices communicated to the provider.

37. During all times relevant to this Complaint, defendants Don J. Wagoner and Wagoner Medical Center, L.L.C. have executed, and been obligated to comply with, IHCP Provider Agreements.

38. During all times relevant to this Complaint, defendant Wagoner Medical Center, L.L.C. was an enrolled Medicaid provider within the meaning of 405 Indiana Administrative Code § 1-1-1 and Indiana Code § 12-15, *et. seq.*

39. During all times relevant to this Complaint, defendants were in the business of providing medical services to Medicaid recipients and receiving payment for these medical services from Indiana Medicaid.

40. Under Indiana Code § 12-15-21-1, a provider who accepts payment from the Medicaid program is deemed to have agreed to comply with the statutes and rules governing the program. Pursuant to the Provider Agreement and the rules of the IHCP program as defined in the Provider Manual, compliance with the Provider Agreement, Provider Manual, program bulletins, and notices are a condition of payment.

DEFENDANTS' FRAUDULENT SCHEME

A. The Indiana Medicaid Billing System for Urine Drug Screen Testing

41. Health care providers enrolled in Indiana Medicaid electronically submit claims to the program for reimbursement using a set of codes that identify the services performed for covered individuals. The codes for medical services and procedures are written by the American Medical Association (AMA) and published annually in a series of books entitled the Current Procedure Terminology, Professional Edition, or CPT. The abbreviation CPT is used within the health care field to both refer to the AMA published book and the individual five digit codes contained within the book (for example

2011 CPT®, and CPT Code 80104 multiple drug classes other than chromatographic method, each procedure). Most codes stay consistent from year to year, although AMA adds some codes and deletes other codes every year. Almost every health care provider in the Unites States codes the services they provide using CPT codes, and almost every insurance company in the Unites States reimburses health care providers based on CPT codes. Federally reimbursed health care programs like Medicaid, Medicare, and Tricare all use CPT codes to identify services and procedures. Each health care program and insurer publishes guidance and rules on which CPT codes are eligible for reimbursement, and the reimbursement rates for those codes for any claims by providers. For some codes, insurers and government health care programs also establish rules for the maximum number of times the code is eligible for reimbursement for each covered individual within a certain time period, and rules for how certain services and procedures can be bundled together or separated when submitting claims for reimbursement. Health care insurance programs may notify their enrolled providers of these rules and policies through enrollment agreements, policy manuals, bulletins and notices, state and federal laws and regulations, or expect compliance with standards of medical practice within each field.

42. For many years prior to, and continuing through the time period relevant to this Complaint, Indiana Medicaid reimbursed physician providers for pathology and laboratory testing and evaluation services for covered individuals, including testing urine samples for evidence of commonly abused controlled substances.

43. There are two general categories of urine drug screen tests: qualitative and quantitative. Qualitative urine drug screen tests determine the presence or absence (positive or

negative), but not the quantity, of a drug present in a urine sample. Quantitative drug tests determine the quantity of a particular drug or drug class in a urine sample.

44. For quantitative drug tests, a chromatographic method using expensive chromatography equipment often is required. During all times applicable to this Complaint, defendants never possessed or used chromatography equipment to analyze urine samples.

45. For qualitative urine drug tests, one type of urine drug test kit is designed to determine if the patient has an individual class of abused drugs in his system such as alcohol, cocaine, opiates, and amphetamines. This is known as a single drug class method.

46. Another type of urine drug test kit for qualitative tests is designed to use a single urine sample to test for multiple drugs or drug classes. This type of urine drug test kit is called a multiplexed screening kit.

47. In some laboratory or pathology testing, it may be necessary to run a test or screen multiple times on the same day to discern an effect on the body over time. For instance, a doctor who suspects diabetes may want to do a blood sugar test several times during a day to determine how the patient's blood sugar levels react to fasting and the presence of glucose. Another example is a doctor who needs to determine how a smaller juvenile patient absorbs a new drug throughout a day to set the correct dosing level for that patient's metabolism and size.

48. Most insurers and government health care programs would reject a second or any subsequent identical test allegedly rendered on the same day to the same patient. They might use a software algorithm to identify duplicate claims and automatically reject any subsequent claims for identical services rendered to the same patient on the same date of service.

49. Indiana Medicaid rules allow an enrolled provider to add an additional code to a claim to indicate that subsequent identical services for the same patient on the same day was in fact rendered for legitimate treatment purposes. As explained in the CPT code book, for that situation, the enrolled provider should record a "91 modifier" alongside the 5-digit CPT code. Hence, when using the 91 modifier when submitting a claim for payment to Indiana Medicaid, the enrolled provider is certifying that the same patient returned to the office later during the same day and provided a new urine sample, and the enrolled provider analyzed the additional urine sample for drugs or drug classes.

50. The 91 modifier is not appropriate for testing using a single urine sample when the patient only comes in once during a particular day even if the urine sample is used for qualitative analysis of multiple drugs or drug classes using a multiplexed screening kit. Nor is the 91 modifier appropriate for repeat screening tests with the same urine sample using a new urine drug test kit because the first test did not yield reliable results for some reason. These rules concerning whether or not the 91 modifier is appropriate for a Medicaid claim were consistent for many years. For example, during March 2009, all enrolled Indiana Medicaid providers, including defendants Don J. Wagoner and Wagoner Medical Center, L.L.C., received IHCP Bulletin BT200907 explaining these rules. Additionally, during February 2011, all enrolled Indiana Medicaid providers, including defendants Don J. Wagoner and Wagoner Medical Center, L.L.C., received IHCP Bulletin BT201102 containing a reminder of those 91 modifier billing rules. Also, during June 2011, all enrolled Indiana Medicaid providers, including defendants Don J. Wagoner and Wagoner Medical Center, L.L.C., received IHCP Bulletin BT201135 containing a reminder of those 91 modifier billing rules. Moreover, additional

AMA sources readily available to defendants with clear explanations of these modifier 91 billing rules included the 2011 CPT® and AMA's 2011 publication entitled "Coding with Modifiers, A Guide to Correct CPT and HCPCS Level II Modifier Usage, Fourth Edition, authored by Deborah J. Grider.

51. During December 2010, all enrolled Indiana Medicaid providers, including defendants, received IHCP bulletin BT201062 announcing a new CPT Code 80104, "drug screen, qualitative; multiple drug classes other than chromatographic procedure." Additionally, before 2011, the 2011 CPT® book became available. In that publication, immediately below the language of CPT Code 80101, medical providers received the following instruction: "For qualitative analysis by multiplexed screening kit for multiple drugs or drug classes, use 80104." From January 1, 2011 through and including January 13, 2013, defendants Don J. Wagoner and Wagoner Medical Center, L.L.C. performed all of its urine drug screen tests qualitatively using a single urine sample on a multiplexed screening kit. Therefore, the unambiguous coding rules in effect during that time period required defendant Wagoner Medical Center, L.L.C. to bill CPT Code 80104 only once, without any modifier, for each patient each day the patient provided a single urine sample that was qualitatively analyzed using a multiplexed screening kit in the laboratory at Wagoner Medical Center, L.L.C.

52. If defendants had billed Indiana Medicaid for CPT Code 80101, or another CPT code for laboratory testing such as CPT Code 80100, only once each time they tested a single urine sample for a single visit by the same patient on the same day using a multiplexed screening kit, defendants would have received an overpayment of only a few thousand dollars or less. Defendants' knowing false statements when, for thousands of tests,

defendants routinely used the 91 modifier to submit 9 or more claims for a single urine drug screen test using a multiplexed screening kit caused the egregious overpayment to defendants from Indiana Medicaid of approximately $1,121,277.76.

B. Defendants False and Fraudulent Claims to Indiana Medicaid for Urine Drug Screen Tests

53. Defendants had a routine practice of requiring patients seeking a prescription for opioid pills or other pain medicine to submit a urine sample for qualitative testing for the presence or absence of nine or more drugs and drug classes.

54. January 1, 2011 was the effective date of new billing rules requiring Indiana Medicaid providers to use CPT Code 80104 only once without any modifier to submit a claim to Indiana Medicaid for each qualitative urine drug screen test using a multiplexed screening kit.

55. Nevertheless, during January 2011, defendants continued to use CPT Code 80101 at least 9 times when billing Indiana Medicaid for testing a single urine sample from a single patient on a single day using a multiplexed screening kit.

56. During or around January 2011, Indiana Medicaid routinely denied all but one claim of defendants' urine drug test claims using CPT Code 80101 each time defendants billed CPT Code 80101 more than one time for the same patient on the same day.

57. Sandy Thompson, the billing manager at defendant Wagoner Medical Center, L.L.C. (WMC), immediately told defendant Don J. Wagoner about the Indiana Medicaid claims denials. She did so pursuant to defendant Don J. Wagoner's instructions to her to inform him any time Indiana Medicaid or another insurance program denied claims. Defendant Don J. Wagoner then directed Sandy Thompson to call Indiana Medicaid and find out why they were denying the claims.

58. Sandy Thompson complied with defendant Don J. Wagoner's orders and called Indiana Medicaid to ask why it denied the urine drug screen claims. After speaking with officials at Indiana Medicaid, Sandy Thompson told defendant Don J. Wagoner that Indiana Medicaid denied the claims based on the new billing rules requiring providers to bill a urine drug screen test for the same patient on the same day only once.

59. After learning the reason for the claims denials, defendants devised a scheme to get paid 9 or more times for each drug screen test using a single urine sample from a single patient visit on a single day with a multiplexed screening kit that cost defendant WMC approximately five dollars. Defendant WMC's billing department employees typed in Indiana Medicaid claims based on the notations on a superbill provided to them by physicians and physician's assistants, including defendant Marilyn L. Wagoner, at defendant WMC. At defendant Don J. Wagoner's direction, defendant WMC's Office Manager, Michelle Wagoner, programmed the billing department's computers so that it would automatically populate 9 claims for CPT Code 80101, with a 91 modifier after each claim, each time a billing department employee typed in CPT Code 80101 only once. Thereafter, by those or other means, either automatically or deliberately, at defendant Don J. Wagoner's direction, defendant WMC's billing staff routinely billed CPT Code 80101 with a 91 modifier at least 9 times every time defendant WMC tested a single urine sample from a single patient visit on a single day using a multiplexed screening kit. Hence, by routinely using the 91 modifier in this fashion, defendants were falsely certifying to Indiana Medicaid that each of the patients had come into WMC's office at least 9 times on a single day and provided 9 separate urine samples that WMC's lab had then separately tested.

60. During monthly staff meetings with defendant WMC's billing department employees, which WMC Office Manager Michelle Wagoner and WMC Billing Manager Sandy Thompson routinely attended and defendant Don J. Wagoner occasionally attended, defendant WMC's policy regarding billing urine drug screen tests was a frequent topic of conversation.

61. During periodic meetings of physicians and physician's assistants at WMC, the subject of revenue generated from insurance billings, including Indiana Medicaid, for urine drug screen tests was a topic of conversation at least once. Defendants Don J. Wagoner and Marilyn L. Wagoner routinely attended those periodic meetings.

62. After defendant WMC's billing manager, Sandy Thompson, discerned that defendants continued to bill Indiana Medicaid 9 or more times for a testing a single urine sample for the same patient on the same day, Sandy Thompson spoke to defendant Don J. Wagoner about the billing pattern. Sandy Thompson recommended to defendant Don J. Wagoner that defendants repay Indiana Medicaid for each instance in which defendants billed CPT Code 80101 for more than one urine drug screen test for the same patient on the same day. Defendant Don J. Wagoner refused and told Sandy Thompson that defendants would not issue any refunds to Indiana Medicaid.

63. Defendants' false and fraudulent claims to Indiana Medicaid for urine drug screen tests using multiplexed screening kits were for services rendered between January 1, 2011 and January 13, 2013, and resulted in approximately 6,433 claims that falsely and fraudulently induced Indiana Medicaid to overpay defendants approximately $1,121,277.76. Defendants have not refunded any of that amount to plaintiffs. A chart summarizing the false claims that defendants submitted to Indiana Medicaid is attached,

and incorporated into, this Complaint as Exhibit 1A. Charts summarizing each of the false claims that defendants submitted to Indiana Medicaid (with personally identifiable information redacted as required by Fed. R. Civ. P. 5.2(a)) are attached, and incorporated into, this Complaint as Exhibit 1B, Exhibit 1C, Exhibit 1D, and Exhibit 1E.

64. By or before November 30, 2016, plaintiffs and defendants Don J. Wagoner and Wagoner Medical Center, L.L.C. executed a tolling agreement stating that the period commencing on January 1, 2017 and ending on January 1, 2018 shall not be included in computing the running of any statute of limitations potentially applicable to any action brought by the United States of America or the State of Indiana regarding defendants' tolled urine drug screen claims to Indiana Medicaid.

VIOLATIONS OF LAW

A. Claims of United States of America

COUNT 1
Federal False Claims Act: Presentation of False Claims
(31 U.S.C. § 3729(a)(1)(A))

65. The United States realleges paragraphs 1 through 64 above as if fully set forth herein.

66. Defendants knowingly presented, or caused to be presented, approximately 6,433 false and fraudulent claims to Indiana Medicaid.

67. The false and fraudulent information in each claim was material to Indiana Medicaid's decision to pay defendants' false claims.

68. Said claims were presented, or caused to be presented, with actual knowledge of their falsity, or with reckless disregard or deliberate ignorance of whether or not they were false.

69. The United States Government sustained a loss from defendants' false and fraudulent claims to Indiana Medicaid.

70. Defendants are liable to the United States under the FCA for three times the loss sustained by the United States plus a civil penalty of not less than $5,500 and not more than $11,000 per false claim and the costs of this civil action brought to recover such penalty and damages. 31 U.S.C. § 3729(a)(1), (3); Federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. 2461 note; Public Law 101-410; 64 Fed. Reg. 47,099, 47,103 (1999).

COUNT 2
Federal False Claims Act: False Statements Material to False Claims
(31 U.S.C. § 3729(a)(1)(B))

71. The United States realleges paragraphs 1 through 70 above as if fully set forth herein.

72. Defendants knowingly made, used, or caused to be made or used, false records or statements material to approximately 6,433 false or fraudulent claims to Indiana Medicaid. Among other false records or statements, defendants: (1) drafted superbills and other documents instructing defendant WMC's coding employees to make entries into defendants' computer that caused the submission of false claims to Indiana Medicaid; and (2) for each patient defendants used or caused to be used 9 or more claims for a single urine drug test using a multiplexed screening kit, often using the 91 modifier, when submitting claims for testing of a single urine sample for the same patient on the same day using a multiplexed screening kit, thereby falsely certifying that they separately analyzed 9 or more urine samples for each patient.

73. Said false records or statements were material to the decisions of Indiana Medicaid to pay defendants' false claims.

74. Defendants made, used, or caused to be made or used, said false records or statements with actual knowledge of their falsity, or with reckless disregard or deliberate ignorance of whether or not they were false.

75. The United States Government sustained a loss from defendants' false and fraudulent claims to Indiana Medicaid resulting from the false records or statements that defendants made, used, or caused to be made or used.

76. Defendants are liable to the United States under the FCA for three times the loss sustained by the United States plus a civil penalty of not less than $5,500 and not more than $11,000 per false claim and the costs of this civil action brought to recover such penalty and damages. 31 U.S.C. § 3729(a)(1), (3); Federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. 2461 note; Public Law 101-410; 64 Fed. Reg. 47,099, 47,103 (1999).

COUNT 3
Federal False Claims Act: False Statements Material to an Obligation to Pay Money (31 U.S.C. § 3729(a)(1)(G))

77. The United States realleges paragraphs 1 through 76 above as if fully set forth herein.

78. During all times relevant to this Complaint, Paragraph 19 of defendants' Provider Agreement with Indiana Medicaid required defendants to "refund within fifteen (15) days of receipt" to Indiana Medicaid "any duplicate or erroneous payment received."

79. Defendants received an overpayment from Indiana Medicaid of approximately $1,121,277.76 caused by defendants' submission to Indiana Medicaid of approximately 6,433 false and fraudulent claims. Defendants never have repaid to Indiana Medicaid the overpayment that defendants received from Indiana Medicaid.

80. Defendants knowingly made, used, or caused to be made or used, false records or statements to conceal defendants' obligation to repay the overpayment that defendant received from Indiana Medicaid. Among other false records or statements, after learning that Indiana Medicaid would not pay 9 urine drug screen claims for testing using a multiplexed screening kit with a single urine sample for the same patient on the same day, rather than repay the overpayment from Indiana Medicaid, defendants executed a scheme whereby they falsely used a 91 modifier for each claim so that Indiana Medicaid would not discover, and continue to pay, the false and fraudulent claims.

81. Said false records or statements were material to the decisions of Indiana Medicaid to pay defendants' false claims and not discover defendants' obligation to repay Indiana Medicaid and then seek repayment from defendants.

82. Defendants knowingly made, used, or caused to be made or used, false records or statements to conceal an obligation to repay money to Indiana Medicaid for payments from Indiana Medicaid with actual knowledge of their falsity, or with reckless disregard or deliberate ignorance of whether or not they were false.

83. The United States Government sustained a loss from defendants' false and fraudulent records or statements concealing defendants' obligation to repay Indiana Medicaid for defendants' false and fraudulent claims.

84. Defendants are liable to the United States under the FCA for three times the loss sustained by the United States plus a civil penalty of not less than $5,500 and not more than $11,000 per false claim and the costs of this civil action brought to recover such penalty and damages. 31 U.S.C. § 3729(a)(1), (3); Federal Civil Penalties Inflation

Adjustment Act of 1990, 28 U.S.C. 2461 note; Public Law 101-410; 64 Fed. Reg. 47,099, 47,103 (1999).

COUNT 4
Federal False Claims Act: Conspiracy to Violate FCA
(31 U.S.C. § 3729(a)(1)(C))

85. The United States realleges paragraphs 1 through 84 above as if fully set forth herein.

86. Defendants conspired to violate 31 U.S.C. § 3729(A)-(B), (G). Among other things, defendants planned among themselves, and other employees of defendant WMC, to devise a scheme to falsely overbill Indiana Medicaid for multiple urine drug screen claims, when in fact only one urine drug test was performed using a multiplexed screening kit, and often concealed the overbilling by falsely using modifier 91 when submitting their claims. Venues for the conspiracy included without limitation monthly billing department meetings; periodic meetings of physicians and physician assistants; informal conversations between defendants and WMC Office Manager Michelle Wagoner; and informal conversations between defendants and WMC Billing Department Manager Sandy Thompson.

87. The United States Government sustained a loss from defendants' successful conspiracy to violate 31 U.S.C. § 3729(A)-(B), (G).

88. Defendants are liable to the United States under the FCA for three times the loss sustained by the United States plus a civil penalty of not less than $5,500 and not more than $11,000 per false claim and the costs of this civil action brought to recover such penalty and damages. 31 U.S.C. § 3729(a)(1), (3); Federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. 2461 note; Public Law 101-410; 64 Fed. Reg. 47,099, 47,103 (1999).

B. Joint Claims of United States of America and State of Indiana

COUNT 5
Payment by Mistake

89. The United States and Indiana reallege paragraphs 1 through 88 above as if fully set forth herein.

90. This is a claim for the recovery of monies paid by Indiana Medicaid to defendants because of mistaken understandings of fact.

91. Indiana Medicaid paid defendants for thousands of urine drug screen claims, which defendants often submitted using the 91 modifier, with the mistaken understanding that defendants tested 9 or more separate urine samples for the same patient on the same day when in fact defendants tested only one urine sample for the same patient on the same day using a multiplexed screening kit.

92. Indiana Medicaid's mistaken belief was material to its decision to pay defendants' urine drug screen claims.

93. Because of the shared financing of payments for Indiana Medicaid services by the United States and the State of Indiana, both the United States and Indiana suffered a loss as a result of the Indiana Medicaid payments to defendants based on a mistake of fact.

94. Defendants are liable to account and pay to the United States and Indiana the payments that Indiana Medicaid made in error to defendants.

COUNT 6
Unjust Enrichment

95. The United States and Indiana reallege paragraphs 1 through 94 above as if fully set forth herein.

96. This is a claim by the United States and Indiana for recovery of monies by which defendants were unjustly enriched.

97. By obtaining Indiana Medicaid funds, directly or indirectly, to which they were not entitled, defendants were unjustly enriched.

98. Because of the shared financing of payments for Indiana Medicaid services by the United States and the State of Indiana, both the United States and Indiana suffered a loss because of defendants' unjust enrichment.

99. Defendants are liable to account and pay to the United States and Indiana the amounts defendants received from Indiana Medicaid to which they were not entitled.

C. Claims of State of Indiana

COUNT 7
Indiana Medicaid False Claims Act: Presentation of False Claims
(Ind. Code § 5-11-5.7-2(a)(1))

100. The State of Indiana realleges paragraphs 1 through 99 above as if fully set forth herein.

101. Defendants knowingly presented, or caused to be presented, approximately 6,433 false and fraudulent claims to Indiana Medicaid.

102. The false and fraudulent information in each claim was material to Indiana Medicaid's decision to pay defendants' false claims.

103. Said claims were presented, or caused to be presented, with actual knowledge of their falsity, or with reckless disregard or deliberate ignorance of whether or not they were false.

104. The State of Indiana sustained a loss from defendants' false and fraudulent claims to Indiana Medicaid.

105. Defendants are liable to the State of Indiana under the INFCA for three times the loss sustained by the State of Indiana plus a civil penalty of not less than $5,500 and not more than $11,000 per false claim and the costs of this civil action brought to recover such penalty and damages. Ind. Code § 5-11-5.7-2(a); Federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. 2461 note; Public Law 101-410; 64 Fed. Reg. 47,099, 47,103 (1999).

COUNT 8
Indiana Medicaid False Claims Act: False Statements Material to False Claims
(Ind. Code § 5-11-5.7-2(a)(2))

106. The State of Indiana realleges paragraphs 1 through 105 above as if fully set forth herein.

107. Defendants knowingly made, used, or caused to be made or used, false records or statements material to approximately 6,433 false or fraudulent claims to Indiana Medicaid. Among other false records or statements, defendants: (1) drafted superbills and other documents instructing defendant WMC's coding employees to make entries into defendants' computers that caused the submission of false claims to Indiana Medicaid; and (2) for each patient defendants used or caused to be used 9 or more claims for a single urine drug test using a multiplexed screening kit, often using the 91 modifier, when submitting claims for testing of a single urine sample for the same patient on the same day using a multiplexed screening kit, thereby falsely certifying that they separately analyzed 9 or more urine samples for each patient.

108. Said false records or statements were material to the decisions of Indiana Medicaid to pay defendants' false claims.

109. Defendants made, used, or caused to be made or used, said false records or statements with actual knowledge of their falsity, or with reckless disregard or deliberate ignorance of whether or not they were false.

110. The State of Indiana sustained a loss from defendants' false and fraudulent claims to Indiana Medicaid resulting from the false records or statements that defendants made, used, or caused to be made or used.

111. Defendants are liable to the State of Indiana under the INFCA for three times the loss sustained by the State of Indiana plus a civil penalty of not less than $5,500 and not more than $11,000 per false claim and the costs of this civil action brought to recover such penalty and damages. Ind. Code § 5-11-5.7-2(a); Federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. 2461 note; Public Law 101-410; 64 Fed. Reg. 47,099, 47,103 (1999).

COUNT 9

Indiana Medicaid False Claims Act: False Statements Material to an Obligation to Pay Money (Ind. Code § 5-11-5.7-2(a)(6))

112. The State of Indiana realleges paragraphs 1 through 111 above as if fully set forth herein.

113. During all times relevant to this Complaint, Paragraph 19 of defendants' Provider Agreement with Indiana Medicaid required defendants to "refund within fifteen (15) days of receipt" to Indiana Medicaid "any duplicate or erroneous payment received."

114. Defendants received an overpayment from Indiana Medicaid of approximately $1,121,277.76 caused by defendants' submission to Indiana Medicaid of approximately 6,433 false and fraudulent claims. Defendants never have repaid to Indiana Medicaid the overpayment that defendants received from Indiana Medicaid.

115. Defendants knowingly made, used, or caused to be made or used, false records or statements to conceal defendants' obligation to repay the overpayment that defendant

received from Indiana Medicaid. Among other false records or statements, after learning that Indiana Medicaid would not pay 9 urine drug screen claims for testing using a multiplexed screening kit with a single urine sample for the same patient on the same day, rather than repay the overpayment from Indiana Medicaid, defendants executed a scheme whereby they falsely used a 91 modifier for each claim so that Indiana Medicaid would continue to pay the false and fraudulent claims.

116. Said false records or statements were material to the decisions of Indiana Medicaid to pay defendants' false claims and not discover defendants' obligation to repay Indiana Medicaid and then seek repayment from defendants.

117. Defendants knowingly made, used, or caused to be made or used, false records or statements to conceal an obligation to repay money to Indiana Medicaid for payments from Indiana Medicaid with actual knowledge of their falsity, or with reckless disregard or deliberate ignorance of whether or not they were false.

118. The State of Indiana sustained a loss from defendants' false and fraudulent records or statements concealing defendants' obligation to repay Indiana Medicaid for defendants' false and fraudulent claims.

119. Defendants are liable to the State of Indiana under the INFCA for three times the loss sustained by the State of Indiana plus a civil penalty of not less than $5,500 and not more than $11,000 per false claim and the costs of this civil action brought to recover such penalty and damages. Ind. Code § 5-11-5.7-2(a); Federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. 2461 note; Public Law 101-410; 64 Fed. Reg. 47,099, 47,103 (1999).

<u>COUNT 10</u>
Indiana Medicaid False Claims Act: Conspiracy to Violate FCA
(Ind. Code § 5-11-5.7-2(a)(7))

120. The State of Indiana realleges paragraphs 1 through 119 above as if fully set forth herein.

121. Defendants conspired to violate (Ind. Code § 5-11-5.7-2(a)(1)-(2), (6)). Among other things, defendants planned among themselves, and other employees of defendant WMC, to devise a scheme to falsely overbill Indiana Medicaid for multiple urine drug screen claims, when in fact only one urine drug test was performed using a multiplexed screening kit, and often concealed the overbilling by falsely using modifier 91 when submitting their claims. Venues for the conspiracy included without limitation monthly billing department meetings; periodic meetings of physicians and physician assistants; informal conversations between defendants and WMC Office Manager Michelle Wagoner; and informal conversations between defendants and WMC Billing Department Manager Sandy Thompson.

122. The State of Indiana sustained a loss from defendants' successful conspiracy to violate Ind. Code § 5-11-5.7-2(a)(1)-(2), (6).

123. Defendants are liable to the State of Indiana under the INFCA for three times the loss sustained by the State of Indiana plus a civil penalty of not less than $5,500 and not more than $11,000 per false claim and the costs of this civil action brought to recover such penalty and damages. Ind. Code § 5-11-5.7-2(a); Federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. 2461 note; Public Law 101-410; 64 Fed. Reg. 47,099, 47,103 (1999).

COUNT 11
Improper Receipt of Medicaid Payments
(Ind. Code § 12-15-23)

124. The State of Indiana realleges paragraphs 1 through 123 above as if fully set forth herein.

125. For services that defendants allegedly rendered from January 1, 2011 through January 13, 2013, defendants received improper payments for laboratory testing from the Medicaid program for services furnished by defendants to Indiana Medicaid recipients.

126. On or about December 8, 2017, Indiana's Medicaid Fraud Control Unit certified the facts alleged in this Complaint to the Indiana Attorney General, who approved the filing of this Complaint pursuant to Ind. Code § 12-15-23-7(*l*).

127. Defendants received improper Medicaid payments from the Medicaid program based on its violations of the Medicaid statutes, rules, and regulations as stated in this Complaint.

128. Defendants knew, or should have known, that they did not provide as claimed the services for which they were billing to, and receiving reimbursements from, Indiana Medicaid.

129. After the exercise of ordinary diligence, the State of Indiana discovered the facts that constitute defendants' violations of the Medicaid program and receipt of improper payments for these violations.

130. Defendants' conduct caused them to receive improper Medicaid payments from the State of Indiana.

131. As a direct and proximate cause of defendants' conduct, the State of Indiana has suffered damages.

132. The State of Indiana, through attorneys for Indiana's Medicaid Fraud Control Unit, notified defendants of the overpayment from Indiana Medicaid described in this

Complaint and demanded that defendants repay the overpayment. Nevertheless, as of the date plaintiffs filed this Complaint, defendants have failed to repay the overpayment as mandated by the Indiana Medicaid statute, regulations, and rules and defendants' Provider Enrollment Agreement and Contract.

133. Defendants are liable to the State of Indiana for any combination of (1) up to three times the amount of the overpayment; (2) a civil penalty of up to $500 for each instance of overpayment; and (3) reasonable costs of the Indiana Attorney General's investigation and enforcement action. Ind. Code § 12-15-23-8(a)(1)-(4).

COUNT 12
Indiana Crime Victims Relief Act
(Ind. Code § 34-24-3-1)

134. The State of Indiana realleges paragraphs 1 through 133 above as if fully set forth herein.

135. Pursuant to the Indiana Crime Victims Relief Act, a victim of a property crime, including the State of Indiana, may bring a civil action against the person who caused the loss. Ind. Code § 34-24-3-1.

136. The State of Indiana has suffered a property loss due to Theft by defendants as defined under Ind. Code § 35-43-4-2 Theft; Receiving Stolen Property.

137. Pursuant to Ind. Code § 35-43-4-2(a)(1), "(a) A person who knowingly or intentionally exerts unauthorized control of the property of another person, with intent to deprive the other person of any part of its value or use, commits theft, a Class D felony. However, the offense is a Class C felony if: (1) the fair market value of the property is at least one hundred thousand dollars ($100,000)."

138. For services to Indiana Medicaid patients that defendants allegedly rendered from January 1, 2011 through January 13, 2013, defendants fraudulently induced, failed to

repay, and otherwise did knowingly exert unauthorized control of an overpayment of approximately $1,121,277.76, which was the property of another, the State of Indiana and the United States Government, with the intent to deprive the State of Indiana and the United States Government of the use or value of that property.

139. Defendants are liable to the State of Indiana for (1) an amount up to three times the amount of Indiana's loss; (2) the costs of this action; (3) a reasonable attorneys' fee; (4) litigation expenses described in Ind. Code § 34-24-3-1(4)-(6); and (5) all other reasonable costs of collection. Ind. Code § 34-24-3-1.

REQUEST FOR RELIEF

WHEREFORE, plaintiffs United States of America and State of Indiana request that this Court enter judgment in their favor against defendants as follows:

1. On behalf of the United States of America:

   A. For Counts 1, 2, 3, and 4 under the federal False Claims Act, the amount of the United States' damages, trebled as required by law, and such civil penalties as are authorized by law.

   B. For Counts 5 and 6 for payment by mistake and unjust enrichment, the damages sustained or the amounts by which defendants were paid by mistake or unjustly enriched, or by which defendant retained monies to which it was not entitled, plus pre-judgment interest, fees, costs, and expenses.

   C. The costs of this action.

   D. All additional and other relief that is just and proper.

2. On behalf of the State of Indiana:

A. For Counts 7, 8, 9, and 10 under the Indiana Medicaid False Claims and Whistleblower Protection Act, the amount of the Indiana's damages, trebled as required by law, and such civil penalties as are authorized by law.

B. For Counts 5 and 6 for payment by mistake and unjust enrichment, the damages sustained or the amounts by which defendants were paid by mistake or unjustly enriched, or by which defendant retained monies to which it was not entitled, plus pre-judgment interest, fees, costs, and expenses.

C. For Count 11 for improper receipt of payments from Indiana Medicaid, any combination of (1) up to three times the amount of the overpayment; (2) a civil penalty of up to $500 for each instance of overpayment; and (3) reasonable costs of the Indiana Attorney General's investigation and enforcement action.

D. For Count 12 under the Indiana Crime Victims Relief Act: (1) an amount up to three times the amount of Indiana's loss; (2) the costs of this action; (3) a reasonable attorneys' fee; (4) litigation expenses described in Ind. Code § 34-24-3-1(4)-(6); and (5) all other reasonable costs of collection.

E. The costs of this action.

F. All additional and other relief that is just and proper.

JURY DEMAND

Plaintiffs United States of America and State of Indiana demand a jury trial on all issues so triable.

Respectfully submitted,

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