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COURT

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF INDIANA

UNITED STATES OF AMERICA EX REL. [UNDER SEAL] AND STATE OF INDIANA EX REL. [UNDER SEAL]	)	C.A. No. 3:05MC0050RM
Plaintiffs,	)	COMPLAINT
v.	)	
[UNDER SEAL]	)	
Defendant.	)	

FILED IN CAMERA AND UNDER SEAL

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF INDIANA

UNITED STATES OF AMERICA EX REL. KATHLEEN MCCOY and JEAN MARIE THOMPSON AND STATE OF INDIANA EX REL. KATHLEEN MCCOY AND JEAN MARIE THOMPSON,	)	C.A. No. 3:05MC0050RM
	)	COMPLAINT FOR VIOLATION OF FEDERAL FALSE CLAIMS ACT, 31 U.S.C.§3729 et seq.
Plaintiffs,	)	
v.	)	
MADISON CENTER,	)	JURY TRIAL DEMANDED
Defendant.	)	FILED IN CAMERA AND UNDER SEAL

Plaintiffs and qui tam Relators Kathleen McCoy and Jean Marie Thompson, through their attorneys Phillips & Cohen LLP and Friedman & Associates P.C. for their Complaint against the Madison Center, allege as follows:

I. INTRODUCTION

1. This is an action to recover damages and civil penalties on behalf of the United States of America arising from false and/or fraudulent statements, records, and claims made and caused to be made by the defendants and/or its agents and employees in violation of the Federal False Claims Act, 31 U.S.C. § 3729 et seq., ("the FCA" or "the Act") and the Indiana False Claims and Whistleblower Act, Indiana Code Chapter 5.5.

2. This _qui_ _tam_ case is brought against defendant Madison Center for knowingly defrauding the federal Government by improperly charging Medicaid for clinical mental health services provided to children. Since at least 1996, Madison Center has been billing for clinical mental health services provided to children under Medicaid's "Community Mental Health Rehabilitation Option." Many of these claims are not eligible for reimbursement because they are "false claims" within the meaning of the federal False Claims Act.

3. Madison Center's knowing misconduct resulting in false claims includes

- referring a large proportion of Medicaid-eligible children who solicit assistance from the Madison Center to day treatment/ partial hospitalization without performing a clinically adequate assessment of the child's background or mental health needs;
- instructing staff to enroll siblings in a family in day treatment/ partial hospitalization per Dr. John Zagotta without regard to whether those siblings need clinical mental health services;
- maintaining many children in "day treatment" with no or inadequate documentation supporting the medical necessity for their continued enrollment even though many children are in day treatment for four to twelve hours per day and for many years and are not attending school as a result;
- failing to provide adequate rehabilitative services in day treatment/ partial hospitalization;

- falsifying and fabricating medical documentation to support medical necessity including back dating and post dating medical necessity sheets and false certifications of diagnosis and treatment plans on medical necessity sheets;
- billing for time spent signing medical necessity forms without performing an adequate review of the patient's history or supporting documentation, and
- miscoding claims under Dr. John Zagotta by using the same diagnostic codes uniformly for all patients.

4. This illegal activity and submission of false claims for reimbursement to federal health care programs including Medicaid is part of a systematic effort by Madison Center to maximize revenues. Senior managers, including Chief Executive Office Jack Roberts, Associate Director Linda Pyfer, Dr. John Zagotta, PsyD, Dr. Brad Mazick, PhD, Dr. John Zwenerman, Associate Director Dr. Aileen Wehren, Director of On Site Schools Steven Bright, Associate Director Marzy Bauer, Dr. Jeff Burnett, Director of Admissions Melissa Gard, Director of Medical Records Jan Turney, and Director of Day Treatment Kevin Patton among others, condone and actively encourage this misconduct. Senior managers direct staff at Madison Center to refer a large proportion of children to day treatment/partial hospitalization or inpatient admission to the hospital and to maintain them in day treatment without adequate assessment, progress reviews or medical record documentation. Senior managers are also aware that in many cases there is no or strikingly inadequate documentation to support a plan of treatment, continuing care or progress of the patient.

5. Madison Center's illegal conduct amounts to a fraudulent scheme to enrich itself and key

employees at the expense of the Medicaid program without serving the needs of the at-risk population of children it purports to serve. As a direct result of Defendant's improper practices, the federal treasury and the treasury for the State of Indiana have been damaged in substantial amount.

6. The FCA was originally enacted in 1863, and was substantially amended in 1986 by the False Claims Amendments Act, Pub.L. 99-562, 100 Stat. 3153. Congress enacted the 1986 amendments to enhance and modernize the Government's tools for recovering losses sustained by frauds against it after finding that federal program fraud was pervasive. The amendments were intended to create incentives for individuals with knowledge of Government frauds to disclose the information without fear of reprisals or Government inaction, and to encourage the private bar to commit resources to prosecuting fraud on the Government's behalf.

7. The Act provides that any person who presents, or causes to be presented, false or fraudulent claims for payment or approval to the United States Government, or knowingly makes, uses, or causes to be made or used false records and statements to induce the Government to pay or approve false and fraudulent claims, is liable for a civil penalty ranging from $5,500 up to $11,000 for each such claim, plus three times the amount of the damages sustained by the federal Government.

8. The Act allows any person having information about false or fraudulent claims to bring an action for himself and the Government, and to share in any recovery. The Act requires that the complaint be filed under seal for a minimum of 60 days (without service on the defendant during that time). As set forth below, defendants' actions alleged in this Complaint also constitute violations of the Indiana False Claims and Whistleblower Act, Indiana Code Chapter 5.5 Based on these provisions, qui

tam plaintiffs and relators Kathleen McCoy and Jean Marie Thompson seek through this action to recover all available damages, civil penalties, and other relief for the federal and state violations alleged herein.

9. While the precise amount of the loss to the federal government and the State of Indiana cannot presently be determined, it is estimated that the damages and civil penalties that may be assessed against the defendant under the facts alleged in this Complaint amounts to millions of dollars.

II. PARTIES

10. Plaintiff/relator Kathleen McCoy is a resident of South Bend, Indiana and has a Masters Degree in Social Work from Indiana University. Ms. McCoy was employed with Madison Center starting on July 29,2002 where she was initially hired as a therapist on the Child and Adolescent Unit. Starting in January 2003, Ms. McCoy transferred to the Admissions Unit for Madison Center where she began to work with co-relator Dr. Jean Marie Thompson.

11. Beginning in 2003, Ms. McCoy witnessed efforts made by senior managers to ensure that a large proportion of juvenile Medicaid patients were directed to day treatment/partial hospitalization or admitted to the hospital. Ms. McCoy also witnessed first hand the serious lack of documentation of treatment plans, progress notes and related materials in patient files. In June 2003, Ms. McCoy became aware that Madison Center employees were seeking to cover up deficiencies in patient files in preparation for a Medicaid audit. Mc. McCoy reported the "doctoring" of charts to authorities with the state Medicaid Surveillance and Utilization Review Unit. Over the next year, Ms. McCoy provided the

state Medicaid Surveillance and Utilization Review Unit with information about the illegal conduct and false claims submitted by Madison Center as alleged in this Complaint.

12. Ms. McCoy has direct and independent knowledge of the allegations set forth in this Complaint and was the "original source," along with Relator Dr. Jean Marie Thompson, of the allegations of fraudulent conduct set forth herein to the government.

13. Plaintiff/relator Jean Marie Thompson is a resident of Osceola, Indiana. Dr. Thompson has a Doctor of Psychology in Clinical Psychology from the Illinois School of Professional Psychology. Dr. Thompson also has a Juris Doctor degree from Georgetown University Law Center. Dr. Thompson has been employed with Madison Center since September 27, 2000. In October 2001, she became the Intake Coordinator. Dr. Thompson is licensed in Indiana as a Psychologist, a Certified Drug and Alcohol Counselor (CADAC I), and a Health Service Provider in Psychology (HSPP).

14. Beginning in or around 2000, Dr. Thompson witnessed the illegal conduct alleged in this Complaint including deliberate efforts by senior managers to increase revenue by referring a large proportion of juvenile Medicaid patients to day treatment/partial hospitalization and inpatient admission to the hospital, billing with a single diagnostic code, and enrolling siblings in day treatment. Dr. Thompson also witnessed the lack of adequate documentation to support medical necessity in patient files and the lack of supervision for diagnosis and treatment of patients by licensed clinical staff.

15. Dr. Thompson was repeatedly pressured to sign charts authorizing treatment for patients

without being permitted to assess the patient or conduct a review of adequate medical records. .In August 2003, Relator Thompson was verbally reprimanded by Dr. Mazick and Clinical Director of Madison Center for Children Chris Schoeninger, L.C.S.W. for not signing enough medical necessity charts. In February 2005, Relator Thompson received a written reprimand for her association with Relator McCoy.

16. From 2003-2004, Dr. Thompson provided the state Medicaid Surveillance and Utilization Review Unit with information about the illegal conduct and false claims submitted by Madison Center as alleged in this Complaint.

17. Dr. Thompson has direct and independent knowledge of the allegations set forth in this Complaint and was the "original source," along with Relator Kathleen McCoy, of the allegations of fraudulent conduct set forth herein to the government

18. Madison Center is a not-for-profit organization providing behavioral healthcare services in St. Joseph, Elkhart, LaPorte, Marshall, Allen and Porter counties in northern Indiana. Madison Center operates through a number of service locations including the Madison Center, the Madison Center for Children, and a number of regional clinics. Madison Center has been providing services under the Medicaid Rehabilitation Option since 1992. Madison Center holds itself out as the largest Medicaid provider in the State of Indiana.

III. JURISDICTION AND VENUE

19. This Court has jurisdiction over the subject matter of this action pursuant to both 28 U.S.C. § 1331 and 31 U.S.C. § 3732, the latter of which specifically confers jurisdiction on this Court for actions brought pursuant to 31 U.S.C. §§ 3729 and 3730. In addition, 31 U.S.C. § 3732(b) specifically confers jurisdiction on this Court over the state law claims asserted in this Complaint.

18. This Court has personal jurisdiction over the defendant pursuant to 31 U.S.C. § 3732(a) because that section authorizes nationwide service of process and because the defendant has at least minimum contacts with the United States.

20. Venue is proper in this District pursuant to 31 U.S.C. § 3732(a) because defendants can be found in, reside in or transact or have transacted business in the Northern District of Indiana.

IV. BACKGROUND

A. MEDICAID REHABILITATION OPTION

21. Medicaid was created in 1965 under Title XIX of the Social Security Act. Funding for Medicaid is shared between the Federal Government and those states participating in the program. Thus, under Title XIX of the Social Security Act ("Medicaid"), 42 U.S.C. § 1396 et seq., federal money is distributed to the states, which in turn provide certain medical services to the poor. Federal Medicaid regulations require each state to designate a single state agency responsible for the Medicaid program.

22. The state agency must create and implement a "plan for medical assistance" that is

consistent with Title XIX and with the regulations of the Secretary of the United States Department of Health and Human Services ("the Secretary"). After the Secretary approves the plan submitted by the State, the state is entitled each quarter to be reimbursed for a percentage of its expenditures made in providing specific types of "medical assistance" under the plan. 42 U.S.C. § 1396b(a)(1). This reimbursement is called "federal financial participation" ("FFP"). For fiscal year 2005, the FFP for Indiana is 62.8%, meaning that the federal government will pay that percentage of the state's Medicaid costs.

23. The Indiana Department of Public Welfare is the administering state agency for the Medicaid program in Indiana. The Centers for Medicare and Medicaid Services (CMS) oversees the Medicaid program.

24. Title XIX of the Social Security Act authorizes Medicaid reimbursement for certain covered rehabilitation services subject to requirements set forth in the Medicaid State Plan for community mental health rehabilitation services.

25. Federal regulations set forth requirements for rehabilitative services and optional targeted case management services eligible for federal Medicaid reimbursement. 42 C.F.R. § 440.130(d) (rehabilitation services); 42 C.F.R. § 431.55©.

26. Starting in 1992, CMS (then the Health Care Financing Administration) initiated efforts

to encourage development by the states of rehabilitation plans to provide services for the mentally ill including for children in need of clinical mental health services. HCFA (CMS) Informational Memorandum (1992) Rehabilitation Services for the Mentally Ill.

27. All services reimbursable under the Medicaid program must meet "medically necessity" and "reasonableness" requirements.

B. Indiana Community Mental Health Rehabilitation Services

28. Since the mid 1990s, Indiana has participated in a Medical Rehabilitation Option (MRO) program for those eligible for Medicaid and available only through designated community mental health centers. Madison Center is a designated community mental health center.

29. MRO allows providers, including Madison Center, to deliver some services not otherwise eligible for Medicaid reimbursement and to use a greater range of employees to deliver those services under the supervision of a qualified mental health professional (QMHP) or a physician.

30. Title 405 of the Indiana Administrative Code (IAC) sets forth relevant provisions governing Community Mental Health Rehabilitation Services in Indiana.

31. 405 IAC 5-21-1 defines "community mental health rehabilitation services" as "outpatient mental health services," "partial hospitalization services," "case management services for people who are seriously mentally ill or seriously emotionally disturbed," and "assertive community treatment intensive case management services."

32. 405 IAC 5-21-1 defines "qualified mental health professional" as a psychiatrist, a physician, a licensed psychologist or a psychologist endorsed as a health service provider in psychology, an individual with at least two years of clinical experience treating persons with mental illness under the supervision of one of the preceding after receiving a masters or doctorate in psychiatry, social work, psychology or certain counseling degrees; a school psychologist; advanced practice nurse; or someone who has documented education, training or experience equivalent to those listed.

33. Medicaid will reimburse for community health services for persons with mental illness when those services are provided through a community mental health center that is an enrolled Medicaid provider and meets applicable laws concerning the operation of community mental health centers and by personnel who meet appropriate federal, state and local regulations for their respective disciplines or are under the supervision or direction of a qualified mental health professional.

34. Reimbursable Medicaid services include "partial hospitalization services" or "day treatment" programs as they are commonly known. The IAC defines "partial hospitalization services" as "group activity programs provided two (2) or more hours per day for individuals who need less than full time hospitalization but more extensive and structured treatment than on an intermittent, hourly basis." Services are provided on "part days, evenings or weekends" and "by a clinical team." The Medicaid procedure code for partial hospitalization/day treatment is X3049.

35. Reimbursable Medicaid services under the rehabilitation option also include "case

management services" which are "goal-oriented activities that assist individuals by locating, coordinating and monitoring necessary care and services appropriate and accessible to the recipient." Such case management services are available to children where the child has a mental illness diagnosis; the child experiences significant functional impairments in key areas; and the mental illness meets certain duration or situational trauma requirements. 405 IAC 5-21-5.

36. Reimbursement for community mental health rehabilitation services depends on the "supervising physician or health service provider in psychology (HSPP) . . . certifying the diagnosis and plan of treatment." 405 IAC 5-21-6 directs that the "supervising physician or health service provider in psychology (HSPP) is responsible for seeing the patient during the intake process or reviewing information submitted by the qualified mental health professionals and approving the initial treatment plan within seven (7) days." Further, "the supervising physician or health service provider in psychology (HSPP) must see the patient or review the treatment plan submitted by the qualified mental health professional at intervals not to exceed ninety (90) days. These reviews must be documented in writing."

37. Additional relevant provisions from the Indiana Administrative Code direct that payment may be denied for a claim where the services claimed cannot be documented by the provider in accordance with Medicaid record keeping requirements. 405 IAC 1-1-4.

38. Medicaid regulations further require that medical records be of sufficient quality to fully

disclose and document the extent of services provided under the Indiana Medicaid program. Records must include the identity of the individual to whom services were rendered, the identity of the provider rendering the service, the identity and position of the provider employee rendering the service, the date on which the service was rendered, the diagnosis of the medical condition of the individual to whom services were rendered, a detailed statement describing services rendered, the location at which services were rendered, and the amount claimed through the Indiana Medicaid program for each specific service rendered. 405 IAC 1-5-1. There are additional requirements for written evidence of physician involvement and personal patient evaluation. Under certain circumstances, medical records must include physician progress notes as to the necessity and effectiveness of therapy and reference to ongoing evaluations to assess progress and redefine goals as part of the therapy program. Id.

39. As a condition of reimbursement under any federal health care program including Medicaid there must be adequate documentation in a patient's medical record of all medical services rendered.

40. Because lack of an adequate medical record undermines the quality of patient care and makes it impossible to verify what level of care was actually provided, it is not proper to bill the Medicare, Medicaid or other federal or state health care programs for care that has not been documented in a patient's medical record in a time and manner that ensures the claimed services were actually provided in the manner claimed and were necessary and appropriate for the patient.

41. With certain exceptions, unlike the majority of Medicaid services which require prior

authorization, community mental health rehabilitation services may be provided without prior authorization. 405 IAC 5-21-7.

C. MRO Provider Manual

42. The MRO Provider Manual provides additional guidance for providers for requirements in the Medicaid Rehabilitation Option.

43. "Treatment plan" is defined as "an individualized plan of care developed by the provider for medical or remedial services treating the disability or improving the member's level of function." Treatment plans are developed after a "clinical assessment" including review of psychiatric symptoms, review of the member's skills and the support needed to function in living, working and learning environments, and review of the strengths and needs of the member."

44. "Supervision" by a physician, psychiatrist or HPSS involves reviewing information submitted by QMHP, approving initial treatment plans and certifying the diagnosis within seven days, seeing the patient or reviewing the treatment plan at intervals not to exceed ninety days, seeing the patient for emergency consultations and when additional consultations are requested, keeping all documentation in the individual treatment record, providing clinical attention in the patient's home, workplace, provider facility, emergency room or wherever attention is needed; and putting in place procedures for emergency provision of medication, first aid or other medical care.

45. The MRO Procedure Manual sets forth the procedure code and description of the

procedure for billing claims for reimbursement from mental health assessment through case management.

46. The MRO Procedure Manual sets forth the procedure code and description of the procedure for billing claims for reimbursement for Partial Hospitalization or "day treatment" programs as they are commonly known.

V. ALLEGATIONS

A. Referrals of Medicaid-Eligible Children to Day Treatment Programs

47. Beginning on or around March 2003, Madison Center instituted a policy of referring a large proportion of children eligible for Medicaid who sought clinical mental health services through Madison Center's intake to day treatment/partial hospitalization or to in patient hospital admission. Clinical staff that did not refer patients to day treatment would be required to justify why they had enrolled the child in a less intensive and less revenue-generating option.

48. The decision to refer Medicaid-eligible children to day treatment has been made because day treatment is financially more profitable for Madison Center than is providing outpatient treatment services. Madison Center can bill $25 per hour per child in day treatment which amounts to approximately $1000/week per patient. As a result, starting in 2002/2003, clinical staff had to justify not sending intakes to day treatment or for inpatient hospital admission.

49. In many cases, the decision to refer Medicaid-eligible children to day treatment has been

made without conducting a clinically adequate individualized assessment of the child's psychosocial needs or drafting a treatment plan by a psychiatrist or a HSPP.

50. Intake employees are generally only high school graduates without degree training in mental health services who have been given the status of "qualified mental health professionals." Intake employees have been instructed to enroll Medicaid-eligible children in day treatment programs without adequate supervision from physicians or HSPP.

51. There are no clinically significant admissions criteria for admission to day treatment/ partial hospitalization readily available to intake personnel.

52. As a result of Madison Center's policy of referring a large proportion of Medicaid-eligible children to "day treatment," the numbers of hours spent on day treatment by Madison Center increased nearly 50% from 2002 to 2004. In 2002, Madison Center partial hospitalization/ day treatment program reported 391,631 hours for all partial hospitalization services. In 2003, Madison Center reported 464,570 hours and in 2004, Madison Center reported 572,398 hours.

53. Total day treatment hours include hours spent in day treatment by adults as well as children. Relators allege based on their experience with admissions and intake to the programs at Madison Center that a proportionate increase in the number of children in day treatment, and the number of hours those children spent in day treatment, occurred from 2003 and 2005 and that the numbers of hours for children in day treatment also rose nearly 50% over the two year period.

54. With the rise in number of hours spent in day treatment admission, key employees at

Madison Center have also had their salaries rise over the same time period.

55. Relators allege, based on their experience with admissions and intake at Madison Center, that many Medicaid-eligible children spend between four and twelve hours per day in day treatment at Madison Center, and may spend many years in day treatment, despite lack of adequate supervision of treatment, coordination of care, or continued review of medical necessity for this high level of therapeutic care.

56. Madison Center routinely submits claims for reimbursement for day treatment/partial hospitalization of children to Medicaid where a clinically adequate assessment of the child's psychosocial needs and where a treatment plan has not been done in a timely manner.

B. Enrollment of Siblings in Day Treatment Programs

57. Madison Center through Dr. John Zagotta has instructed staff to routinely enroll in day treatment/partial hospitalization siblings of Medicaid-eligible children admitted to day treatment whether or not the siblings have clinically significant severe psychological needs that would justify medical necessity for admission to day treatment for those siblings.

58. In many cases, there is no medical necessity for admission of siblings of children admitted to day treatment at Madison Center. Madison Center presents the program to families with one child in day treatment as a way to provide custodial care for all siblings in the family and case management benefits that are not medical e.g. transportation of children.

59. Dr. Zagotta has instructed staff to enlist siblings in a family with only one family

assessment appointment. Dr. Zagotta has instructed staff to use the information from the first sibling and just change each name to enroll siblings in day treatment. Dr. Sue Connaughton refused to enroll siblings in this manner in day treatment and was supported in this decision by Dr. Linda Finn. As a result, Dr. Connaughton was forced to resign and Linda was demoted at Dr. Zagotta's instigation for not following his instructions.

60. Siblings admitted to day treatment have not had an adequate assessment of the child's psychosocial needs or a treatment plan performed in a timely manner.

61. Madison Center submits claims for reimbursement to Medicaid for siblings of children admitted to day treatment programs without documentation of the medical necessity for enrollment of these siblings in day treatment programs.

C. Lack of Adequate Documentation of Treatment Plans for Medicaid-Eligible Children in Day Treatment Programs

62. General principles of medical record documentation require that the documentation of each patient include the reason for the encounter and relevant history, examination findings and prior diagnostic test results; assessment, clinical impression or diagnosis; plan for care; and date and legible identity of the observer. If not documented, the rationale for treatment should be easily inferred and past and present diagnoses should be accessible. The documentation must support the claimed services reported on the health insurance forms.

63. For mental health claims, a psychosocial assessment must be performed and current

psychiatric or psychological symptoms and conditions must be documented to support a written plan of treatment. 405 IAC 5-21-6 directs that the "supervising physician or health service provider in psychology (HSPP) is responsible for seeing the patient during the intake process or reviewing information submitted by the qualified mental health professionals and approving the initial treatment plan within seven (7) days." Further, "the supervising physician or health service provider in psychology (HSPP) must see the patient or review the treatment plan submitted by the qualified mental health professional at intervals not to exceed ninety (90) days. These reviews must be documented in writing."

64. Under the Medicaid Rehabilitation Option, physicians and HSPP are the gatekeepers to ensure medical necessity for services. At Madison Center, however, the independence of physicians and HSPPs has been compromised and physicians and HSPPs are limited in their exercise of independent discretion over treatment decisions. As a result, treatment programs are often not based on the standard of practice and least restrictive setting but on financial incentives for Madison Center and its employees.

65. For partial hospitalization/ day treatment programs, the number of days per week and number of hours per day must be indicated in the individual treatment plan. In addition, services to be provided through day treatment necessary to stabilize the patient's level of function and assist them in crisis situations for members experiencing psychiatric conditions, must be provided in the individual treatment plan. Goals and interventions must be identified in the individual treatment plan.

66. Madison Center routinely ignores even the most basic requirements of medical record

documentation such that medical records underlying claims for reimbursement submitted to Medicaid are often in total disarray.

67. Initial treatment plans for Medicaid-eligible children are routinely not approved within seven days of admission of the child. Treatment plans for Medicaid-eligible children are routinely not reviewed by physicians or HSPPs in intervals not exceeding ninety (90)days.

68. Documentation often does not support the number of hours/ units billed or the extent of services for which claims are submitted. For example, Madison Center routinely submits claims for reimbursement to Medicaid for hours spent by Medicaid-eligible children where the corresponding documentation does not support the claim of how much time is spent in the program.

69. Madison Center maintains Service Activity Logs (SALs) to document hours spent by employees, including mental health professionals, in various activities. A comparison of the SALs with claims for number of hours spent by Medicaid-eligible children in day treatment reveals that far more hours are being recorded in the SAL than on daily notes of participation in the medical record. Hours claimed on the SALs may not be used as an adequate substitute for documenting hours in the medical record. To the extent Madison Center seeks to justify claims with reference to the number of hours recorded on SALs, these claims should be denied without adequate medical record documentation.

70. Failure to maintain adequate medical record documentation greatly impairs quality of care for mental health patients at Madison Center. Without adequate documentation, mental health professionals cannot assess the patient's needs or project whether goals are met.

71. In June 2003, Relator McCoy became aware of efforts by senior personnel at Madison Center to "clean up" and "doctor" medical records in preparation for an expected Medicaid audit.

72. Relator McCoy alerted Medicaid authorities that Madison Center was attempting to cover up its lack of adequate medical record documentation

73. Within a few days of Relator McCoy warning Medicaid authorities of efforts to fabricate medical records in preparation for an audit, auditors for the Indiana Medicaid program raided the Madison Center on June 30, 2003.

74. As a result of the audit initiated in part by Relator McCoy's notification of the Indiana Medicaid authorities of attempts by Madison Center to cover up the lack of adequate medical record documentation, Health Care Excel Surveillance and Utilization Review conducted an audit of records at Madison Center from March 1, 2001 to May 31, 2002. That audit resulted in a calculation of overpayment to Madison Center of $10,710,414.58.

75. The audit conducted by Health Care Excel Surveillance and Utilization Review for Indiana Medicaid addressed many issues of lack of adequate medical record documentation, overbilling of time, incorrect units of service and incorrect billing for medication/somatic treatment.

76. The Medicaid audit did not address the lack of medical necessity for Medicaid-eligible

children and their siblings being referred to day treatment/ partial hospitalization and Madison Center's continued submission of claims for reimbursement for services provided to these children with lack of adequate documentation of medical necessity.

77. The Medicaid audit did not address the time period of May 31, 2002 to present during which Madison Center has continued to submit claims for reimbursement for services provided to Medicaid-eligible children where documentation in the medical record is inadequate and not provided in a timely manner as required by Medicaid regulations. The Medicaid audit did not address the lack of quality treatment for children in day treatment.

78. Claims for reimbursement are routinely submitted to Medicaid for services where the documentation in the medical record is inadequate to support a claim of medical necessity. Those claims are not eligible for reimbursement.

D. Failure to Provide Adequate Rehabilitative Services in Day Treatment Program

79. Under the Indiana MRO Provider Manual, day treatment/partial hospitalization refers to a structured group activity program, with scheduled components of two hours or more, but less than 24 hours per day. Partial hospitalization is to be provided for patients who require less than full time hospitalization but more extensive or structured treatment than intermittent, hourly outpatient mental health services such as psychosocial rehabilitation, intensive outpatient treatment, clubhouse services, or day programs.

80. The clinical supervisor of the day treatment program must be on site at least twice weekly to satisfy service standards and must monitor services sufficiently to ensure familiarity with the population served and the characteristics of the specific services provided.

81. Diagnostic impressions requiring direct observation of function and interactions to develop must be made daily to develop an individualized treatment plan. Participation in the service must be recorded daily by partial hospitalization staff.

82. Weekly reviews and updates of progress must be documented in the patient's medical record including documentation of dates of services, service, time duration or length of service, and significant occurrences.

83. Partial hospitalization services are to integrate treatment interventions including group psychotherapy, individual, group or family counseling, occupational therapy, activity therapies, clubhouse activities, ADL skills, goal-oriented intervention and creative expression therapies directed toward eliminating psychosocial barriers.

84. Partial hospitalization/ day treatment services at Madison Center are inadequate to meet the criteria specified under state Medicaid requirements.

85. Deficiencies in the day treatment/ partial hospitalization program for Medicaid-eligible children are often such that they amount to providing no treatment services. Patients do not receive group psychotherapy, occupational therapy, activity therapies, clubhouse activities, ADL skills, goal-

oriented intervention and creative expression therapies directed toward eliminating psychosocial barriers in an adequate or timely manner. Although they may receive some individual and family therapy, therapy services are not supervised by a licensed professional. Quite frequently, children placed in day treatment/partial hospitalization at Madison Center receive no or little what could be characterized as treatment services or intervention. Instead, day treatment offers only a crude behavioral modification system applied in the same manner to all patients. Lack of adequate treatment services is particularly shocking given that many children in partial hospitalization/ day treatment at Madison Center are enrolled at a young age (between ages 3 and 5 +) and may spend many years attending day treatment for many hours per day (from 4-12 hours per day).

86. Claims for reimbursement for patients in day treatment/ partial hospitalization are routinely submitted to Medicaid where the patients have received little or no adequate treatment services. Such claims are not eligible for reimbursement.

E. Falsification and Fabrication of Medical Record Documentation by Mental Health Professionals to Support Medical Necessity

87. Medical record documentation at Madison Center is routinely fabricated and altered to justify claims for reimbursement for services provided to Medicaid-eligible children.

88. Dr. Brad Mazick backdates medical record documentation for medical necessity in charts. Drs. Mazick and Zagotta backdated charges before the 2003 audit. In addition, Dr. Mazick requests other staff to backdate charts by many months and even years to create medical necessity

documentation so that claims are paid. Drs. Mazick also signs a significant number of charts, as many as thirty at one time, without reviewing the documentation for medical necessity.

89. During the time Dr. John Zagotta was Intake Director at Madison Center for Children, a high number of intakes were given the diagnosis of Adjustment Disorder with a GAF of 55 regardless of the patient's actual symptoms or condition or appropriate medical diagnosis.

90. Claims for reimbursement are routinely submitted to Medicaid that are not eligible for reimbursement because documentation has been fabricated or falsified.

F. Miscoding Claims and Billing for Time Spent Signing Patient Charts.

91. Dr. Brad Mazick and Dr. Jeff Burnett routinely bill one unit of time (15 minutes) to Medicaid for each chart he reviews and signs even though he usually does not spend fifteen minutes reviewing each chart. Dr. Mazick may sign as many as 20-50 charts within a day in addition to his other tasks. Dr. Mazick also encourages other HSPPs to sign large numbers of charts by offering an inducement of bonuses based on the utilization rate for their time.

92. Claims for reimbursement for time spent reviewing and signing charts should not be reimbursable unless it directly benefits the patient or revisions have been made to the treatment plan. Dr. Mazick and Dr. Jeff Burnett do not perform an adequate, or often any, review of medical record documentation to support medical necessity of the charts he signs. Claims for reimbursement for time spent reviewing and signing charts should not be reimbursable for the unit charged as Dr. Mazick also does not spend fifteen minutes reviewing each chart.

G. Billing for Psychological Testing of Medicaid-Eligible Children

93. Dr. Echo Arnett and Dr. Dawn Kuzinski have routinely conducted psychological tests on Medicaid-eligible children and maintain raw data from the tests without writing reports to document the results of the testing in the child's medical record.

94. Claims for reimbursement for psychological testing and written reports have been submitted and are routinely submitted for psychological tests where no reports have been written to document the results of the tests in the child's medical record. Accordingly, Medicaid has paid for testing which will serve no useful purpose because, without the results of the testing recorded in a written report, appropriate mental health services cannot be identified or provided for the patient in whose name the claim was submitted.

95. Such claims for psychological testing without a written report are not eligible for reimbursement under Medicaid.

H. Billing for Substance Abuse Treatment

96. Madison Center for Children submits claims for reimbursement for alcohol and drug screening evaluations during periods it did not have a certified substance abuse counselor on staff.

97. From October 2000 to August 2003, Madison Center for Children also submitted claims for substance abuse treatment where no or inadequate treatment services are provided. The only treatment provided is often psychoeducational – for example, watching videos – but not therapeutic.

98. Claims for reimbursement for substance abuse treatment where no or inadequate treatment services have been provided are not eligible for reimbursement.

VI. RETALIATION SUFFERED BY RELATORS MCCOY AND THOMPSON

A. Relator Kathleen McCoy Constructively Terminated from Madison Center

99. Starting in 2003, Relator McCoy objected to many of the practices alleged in this Complaint. In June 2003, Relator McCoy alerted Medicaid authorities to efforts being made by senior officials at Madison Center to "clean up" files in preparation for a Medicaid audit.

100. Between 2003 and 2004, Relator McCoy communicated with Medicaid officials about illegal practices at Madison Center and sought to raise awareness about Madison Center's illegal practices among employees.

101 In March 2004, Relator McCoy was compelled to resign from her position at Madison Center under duress from retaliation from senior officials at Madison Center in response to Relator McCoy's "whistleblowing" activities.

102. Since leaving her employment at Madison Center in 2004, Relator McCoy has been unable to obtain work in her professional field as a social worker.

B. Relator Jean Marie Thompson Demoted

103. Starting in 2003, Relator Thompson objected to many of the practices alleged in this Complaint.

104. Between 2003 and 2004, Relator Thompson communicated with Medicaid officials about illegal practices at Madison Center and sought to raise awareness about Madison Center's illegal practices among employees.

105. In March 2005, Relator Thompson was compelled to move to a demoted position at Madison Center under duress from retaliation from senior officials at Madison Center in response to her "whistleblowing" activities.

COUNT I

False Claims Act

31 U.S.C. §3729(a)(1)

106. Plaintiffs reallege and incorporates by reference the allegations in paragraphs 1-105

107. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. § 3729 *et seq.*

108. Through the acts described above, defendant Madison Center knowingly presented, or caused to be presented, false or fraudulent claims, to the United States Government, in order to obtain government reimbursement provided under Medicaid.

109. As a result of these false claims, the United States has been damaged and continues to be damaged, in an amount yet to be determined.

COUNT II

False Claims Act

31 U.S.C. §3729(a)(2)

110. Plaintiffs reallege and incorporate by reference the allegations in paragraphs 1-105.

111. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. § 3729 *et seq.*

112. Through the acts described above, defendant Madison Center has knowingly made, used, and caused to be made and used, false records and statements to get false or fraudulent claims paid through government reimbursement under Medicaid.

113. As a result of these false claims, the United States has been damaged and continues to be damaged, in an amount yet to be determined.

COUNT III

False Claims Act

31 U.S.C. §3729(a)(7)

114. Plaintiffs reallege and incorporate by reference the allegations in paragraphs 1-105.

115. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. § 3729 *et seq.*

116. Through the acts described above, defendant Madison Center knowingly failed to reimburse money wrongfully paid and owed to the federal Medicaid program.

117. As a result of these "reverse" false claims, the United States has been damaged and continues to be damaged, in an amount yet to be determined.

COUNT IV

Indiana False Claims and Whistleblower Protection Act
Indiana Code Chapter 5.5

118. Plaintiffs reallege and incorporates by reference the allegations in paragraphs 1- 105 above as though fully set forth herein.

119. This is a claim for treble damages and penalties under the Indiana False Claims and Whistleblower Protection Act.

120. By virtue of the acts described above, defendant knowingly presented or caused to be presented, false or fraudulent claims to the Indiana State Government for payment or approval.

121. By virtue of the acts described above, defendant knowingly made, used, or caused to be made or used false records and statements, and omitted material facts, to induce the Indiana State Government to approve and pay such false and fraudulent claims.

122. As a result, Indiana State monies were lost through the payment of such false and fraudulent claims.

123. By reason of defendant's acts, the State of Indiana has been damaged, and continues to

be damaged, in substantial amount to be determined at trial. Additionally, the Indiana State Government is entitled to the maximum penalty of $5000 for each and every violation alleged herein.

COUNT V

False Claims Act

31 U.S.C. §3730(h)

124. Plaintiffs repeat and reallege each and every allegation contained in paragraphs 1-105.

125. This is a claim for reinstatement, two times the amount of back pay, interest on the back pay, and special damages for retaliatory constructive discharge of Relator McCoy as provided by the False Claims Act, 31 U.S.C. §3730(h), and the Indiana False Claims and Whistleblower Protection Act, and damages for retaliation directed at Ms. McCoy.

126. By virtue of the acts described above, defendant constructively discharged Relator McCoy because of lawful acts done in furtherance of an action under 31 U.S.C. §3729 et seq.

COUNT VI

False Claims Act

31 U.S.C. §3730(h)

127. Plaintiffs repeat and reallege each and every allegation contained in paragraphs 1- 105.

128. This is a claim for damages associated with the retaliatory demotion of Relator Thompson as provided by the False Claims Act, 31 U.S.C. §3730(h), and the Indiana False Claims and Whistleblower Protection Act, and damages for subsequent harassment of Dr. Thompson.

129. By virtue of the acts described above, defendant has retaliated against Relator Thompson because of lawful acts done in furtherance of an action under 31 U.S.C. §3729 et seq.

PRAYER

WHEREFORE, plaintiffs pray for judgment against defendant as follows:

1. that Defendant cease and desist from violating 31 U.S.C. § 3729 et seq.;

2. that this Court enter judgment against defendant in an amount equal to three times the amount of damages the United States has sustained because of Defendant's actions, plus a civil penalty of not less than $5,500 and not more than $11,000 for each violation of 31 U.S.C. § 3729;

3. that plaintiffs be awarded the maximum amount allowed pursuant to § 3730(d) of the False Claims Act;

4. that this Court enter judgment against defendant in an amount equal to three times the amount of damages the State of Indiana has sustained because of Defendant's actions, plus a civil penalty of $5000 for each violation of Indiana False Claims and Whistleblower Protection Act;

5. that plaintiffs be awarded the maximum amount allowed pursuant to section 5-11-5.5-6 of the Indiana False Claims and Whistleblower Protection Act

6. that plaintiffs be awarded all costs of this action, including attorneys' fees and expenses; and

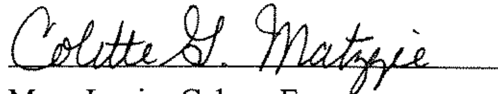
7. that the United States, the State of Indiana, and plaintiffs recover such other and further

relief as the Court deems just and proper.

DEMAND FOR JURY TRIAL

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, plaintiffs hereby demand a trial by jury.

Dated: September 28, 2005



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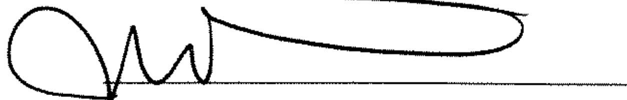

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