IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
LUFKIN DIVISION

UNITED STATES OF AMERICA *ex rel.* THE STATE OF TEXAS *ex rel.* KAREN REYNOLDS Plaintiffs, v. PLANNED PARENTHOOD GULF COAST F/K/A PLANNED PARENTHOOD OF HOUSTON AND SOUTHEAST TEXAS, INC., Defendant.	§ § § § § § § § § § § § § § § §	Civil Action No. 9-09-CV-124

THIRD AMENDED COMPLAINT
AND DEMAND FOR JURY TRIAL

Introduction

1. KAREN REYNOLDS ("Relator") brings this action on behalf of the United States of America and the State of Texas against Defendant for treble damages and civil penalties arising from Defendant's false statements and false claims in violation of the federal False Claims Act, 31 U.S.C. §§ 3729 *et seq.*, and the TEXAS HUMAN RESOURCES CODE §§ 32.039, *et seq.*, and 36.002, *et seq*. The violations include billing for medical services not rendered, billing for unwarranted medical services, billing for services not covered by Medicaid, and creating false information in medical records which was material to billing for medical services.

2. As required by the False Claims Act, 31 U.S.C. § 3730(b)(2), Relator has provided to the Attorney General of the United States, and to the United States Attorney for the Eastern District of Texas, a statement of all material evidence and information related to this Complaint. The disclosure statement presented to the United States Attorney General and the United States Attorney is supported by material evidence known to Relator at the time of her filing, establishing the existence of Defendant's false claims. Because the statement includes attorney-client communications and work product of Relator's attorneys, and is submitted to the Attorney General and to the United States Attorney in their capacity as potential co-counsel in this litigation, Relator understands this disclosure to be confidential and privileged.

3. As required by the Texas Medicaid Fraud Prevention Act, TEX. HUM. RES. CODE § 36.102(a), Relator has provided to the Attorney General of the State of Texas a statement of all material evidence and information related to this Complaint. The disclosure statement presented to the Texas Attorney General is supported by material evidence known to Relator at the time of her filing, establishing the existence of Defendant's false claims. Because the statement includes attorney-client communications and work product of Relator's attorneys, and is submitted to the Texas Attorney General in his capacity as potential co-counsel in this litigation, Relator understands this disclosure to be confidential and privileged.

Jurisdiction and Venue

4. Jurisdiction in the Eastern District of Texas is proper, pursuant to the federal False Claims Act, 31 U.S.C. §§ 3730(b) and 3732(a) and (b), because Relator is a private person bringing a civil action on behalf of the United States Government for violations of Section 3729, *et seq*., and pursuant to 28 U.S.C. § 1345 because the United States Government is a Plaintiff, and because

Relator is bringing a civil action brought under the laws of the State of Texas for the recovery of funds paid by a State agency also arising from the transactions or occurrences as proscribed under Section 3729, *et seq*., and TEX. HUM. RES. CODE §§ 32.039, *et seq*., and 36.002, *et seq*., and because Defendant transacted its business within the Eastern District of Texas. Furthermore, this Court possesses proper jurisdiction pursuant to 28 U.S.C. §§ 1331 (federal question) and 1367 (supplemental jurisdiction).

5. Venue in the Eastern District of Texas is proper, pursuant to 31 U.S.C. § 3732(a), because many of the acts proscribed by 31 U.S.C. §§ 3729 *et seq.* and complained of herein took place in this District, and is also proper pursuant to 28 U.S.C. §§ 1391(b) and (c), because at all times material and relevant, Defendant was qualified to conduct business in the State of Texas, and did conduct business in the State of Texas, and did transact and do business in the Eastern District of Texas.

Parties

6. Relator Karen Reynolds is a citizen of the United States and a resident of the State of Texas. From October 1999 through February 2009, Relator was an employee of Defendant, Planned Parenthood Gulf Coast f/k/a Planned Parenthood of Houston and Southeast Texas, Inc., (hereinafter "PPGC"). Relator brings this action based on her direct, independent, and personal knowledge, obtained during the course of her employment with Defendant.

7. Relator is an original source of this information provided to the United States, as she obtained her knowledge first-hand by personally observing the conduct described herein during the course of her employment. As such, she has direct and independent knowledge of the information on which the allegations are based. Relator voluntarily provided this information to the government

before filing an action under the False Claims Act based on such information.

8. The United States of America ("U.S.") and the State of Texas ("Texas") fund medical service provision and pharmaceutical delivery grants and programs through the federal Department of Health and Human Services, the Texas Medicaid & Healthcare Partnership, the Texas Department of State Health Services, and the Texas Health and Human Services Commission. These departments and departmental programs oversee medical services and pharmaceutical delivery services for family planning preventative care, counseling services, and educational services. These departments, departmental programs, and contract providers are federally funded by Title V (42 U.S.C. § 701, *et seq*.), Title X (42 U.S.C. § 300a, *et seq*.), Title XIX (42 U.S.C. § 1396a, *et seq*.), and Title XX (42 U.S.C. § 1397, *et seq*.).

9. Defendant PPGC owns and operates at least ten health clinics in Texas and two health clinics in the State of Louisiana, with the represented purpose of providing medical services, delivering pharmaceuticals, and providing counseling and educational services and materials for family planning and family planning preventative care. PPGC and its clinics are grantees or recipients of federal funds provided through Texas programs and/or provided directly through U.S. programs.

10. PPGC maintains its executive and corporate administrative offices at 4600 Gulf Freeway, Houston, Texas 77023. This is also the address of its registered agent, Peter J. Durkin. PPGC's directors and officers include Karen O. George, Chair; Dana Hurt, Vice Chair; Peter Durkin, President/CEO; Sara L. Brown, Treasurer; Allison E. Bell, Secretary; Melaney Linton, COO; and Jeffrey Palmer, CFO. PPGC is comprised of the following twelve clinics: the Fannin Clinic, 3601 Fannin, Suite 100, Houston, TX; the Greenbriar Clinic, 3727 Greenbriar, Suite 118,

Stafford, TX; the 1960 Clinic, 3995 F.M. 1960 W, Houston, TX; the Southwest Clinic, 6121 Hillcroft, Suite O, Houston, TX; the Lufkin Clinic, 205 Shands Drive, Lufkin, TX; the Bryan Clinic, 4112 E. 29th Street, Suite 100, Bryan, TX; the Huntsville Clinic, 2405 Avenue I, Suite C, Huntsville, TX; the Greenspoint Clinic, 11834 Airline Drive, Houston, TX; the Dickinson Clinic, 3315 I-45, Dickinson, TX; the Rosenburg Clinic, 4203 Avenue H, Suite 7, Rosenburg, TX; a clinic in Baton Rouge, LA; and a clinic located in New Orleans, LA.

Summary of the Complaint

11. At all times relevant herein, pursuant to corporate policies and procedures designed to maximize revenue received from government health care programs, such as the Women's Health Program [WHP], Medicaid, and Title XX, PPCG trained and instructed the employees at its twelve regional clinics to bill the government for medical services that were not medically necessary, to bill the government for medical services that were not actually provided, to bill the government for services that are not covered by Medicaid, and to falsify information in patient medical charts that was material to claims submitted to the government for reimbursement in an effort to evade detection of Defendant's fraudulent billing practices.

Facts Common to All Counts

12. Relator Karen Reynolds was an employee of Defendant PPGC from October 1999 through February 2009. Relator held the position of "Health Center Assistant" at Defendant's Lufkin Clinic, located in Lufkin, Texas. During the course of her employment, Relator worked with a number of other PPGC employees who, like Relator, were instructed by Defendant to include fraudulent charge entries in patients' billing records and to falsify patient chart information to

support the fraudulent charges. PPGC used said fraudulent records to submit false claims for payment to Texas and Federal government health programs as described in ¶ 34(i) below.

All policies and conduct complained of herein occurred throughout the entire period of Relator's employment at PPGC, from October 1999 through February 2009, at all of PPGC's clinics. The fellow employees of Relator who, pursuant to Defendant's corporate policies, regularly engaged in the activities complained of herein throughout the entire time of Relator's employment, including the entry of billing codes for services either not rendered, not medically necessary, or not covered by Medicaid and the creation of materially false information in patient charts, include the following:

- Health Center Assistants – Paola Carrizales, Laura McQueen, Suzy Briedenthall, Flo Jaramillo, Kelly Huffhines, Gloria Ivey, Verna McCarver, Kelly Madkins; and
- Nurse Practitioners – Bonnie Smith, Della Connor

The employees and directors of Defendant responsible for creating, communicating, and overseeing implementation of all policies complained of herein, for entering illegitimate billing codes, and for submitting and/or causing to be submitted false claims to the government, include the following:

- Clinic Directors and Assistant Clinic Directors – Sandra Smolenski (Clinic Director - Fannin Clinic), Diana Wheeler (Lufkin Clinic), Michelle Green (Lufkin Clinic), Regina Whittmann (Lufkin Clinic), and Kimberly Cottle (assistant director of Lufkin clinic); and
- Corporate Officers and Directors of Defendant – Peter Durkin, Melany Linton, Keetha Buster, Debbie Dean, Laurie McGill, Melanie Wood, Pam Whitaker, Tracy Chastine, Marina Lansenberg,

A detailed chart of potential witnesses, including additional corporate officers, directors, and employees, along with a summary of each person's actions related to the case (and expected knowledge of relevant facts) is attached as Exhibit 1, and incorporated by reference herein.

13. Federal law regarding Medicaid funding requires states receiving such funds to adopt state plans for medical assistance that contain specified contents and are approved by the Secretary of the Health and Human Services Department.

14. In providing for Medicaid coverage of family planning services, federal law expressly restricts those entities qualified to provide Medicaid-covered family planning services to entities that are eligible for payments under a state Medicaid plan.

15. According to the Texas Health and Human Services Commission ("HHSC"), which oversees the Texas Medicaid Program, medical service providers who desire to be eligible for Medicaid reimbursement must complete a Medicaid Provider Enrollment Application and enter into a written agreement with the state. Federal Medicaid regulations likewise require such an agreement. Thus, Defendant was required, as a condition of participation in the Texas Medicaid Program, to enter into the written HHSC Medicaid Provider Agreement ("Agreement").

16. The Agreement incorporates by reference the Texas Medicaid Provider Procedures Manual ("Manual") and mandates that providers comply with all requirements of the Manual, as well as all state and federal laws governing or regulating Medicaid. The Manual, in accordance with federal Medicaid regulations and the requirements of Title 1, Texas Administrative Code §§ 354.1131 and 354.1149, mandates that all services, supplies, and items billed by a provider for Medicaid reimbursement must be medically necessary and that patient medical records document the medical necessity of all services documented. In accordance with Title 1, Texas Administrative

Code § 354.1004, the Agreement further expressly conditions payment for Medicaid goods and services on the provider's creation and maintenance of accurate records, including all records necessary to demonstrate the extent and medical necessity of all services provided, as well as all records necessary to verify the correctness of all claim amounts paid by Medicaid.

17. The Agreement imposes an affirmative duty on the provider to verify that all Medicaid payments received are for services that were actually rendered and medically necessary.

18. By signing the Agreement, a provider certifies its understanding of and willingness to comply with the terms of the Agreement, as well as its understanding that the creation of any materially false statement, pertinent omission, or misrepresentation in connection with its enrollment application or claims for reimbursement could result in all paid services being declared an overpayment and subject to recoupment, as well as imposition of other sanctions and penalties.

19. By entering into the HHSC Medicaid Provider Agreement, Defendant certified that it understood and would comply with all the requirements thereof.

Factual Basis of Relator's Personal Knowledge

20. As Health Center Assistants, Relator and her fellow employees were responsible for a variety of duties including: conducting in-center medical testing; recording patient services in the patients' medical charts; assisting nurse practitioners and registered nurses with patient services; delivery of pharmaceuticals to patients; recording medical billing codes in patients' charts; entering medical and pharmaceutical billing codes into PPGC billing software (which were subsequently submitted by PPGC to the government for reimbursement through the process described in ¶ 34(i) below); participating in voluminous "chart reviews" in order to reconcile patients' chart information with claims submitted to the government; assisting clinic director(s) in preparation for internal and

external audits; and other general administrative support duties. Relator also regularly attended meetings at which PPGC directors, officers, and managers directed clinic employees in ongoing strategies to maximize corporate revenues. The directors and officers leading these revenue strategy meetings included Peter Durkin, Melany Linton, and Laurie McGill. At other times, the meetings were directed by Diana Wheeler or Michelle Green.

21. During her employment with PPGC, Relator was provided with memorandums drafted by the corporate officers (Durkin, Linton, and McGill), which described the revenue generating strategies and policies complained of herein. Memorandums were also drafted by the local Lufkin Clinic directors (Wheeler and Green) on the same subjects. Finally, Relator received emails from both corporate and local managers on the subject of raising Medicaid, WHP, and other governmental program pay-per-visit figures and total revenue for PPGC clinics by billing for services regardless of whether they were medically necessary or ever actually provided. Each month, the directors of each clinic were required to post monthly revenue goals on the glass partition at the receptionist's desk to constantly remind employees of the need to maximize government billing so the clinic could "make its revenue goals." These monthly goals included separate revenue goals for each revenue source (*i.e.*, WHP, Medicaid, Title XX, Self-Pay, and Donations).

Relators' Knowledge Relates to Defendant's Policies and Procedures at All Clinics

22. For the entire period of her employment with Defendant PPGC, Relator witnessed that all policies and procedures relating to billing requirements, health care services to be provided, personnel training, creation and documentation of medical records, billing records, and general clinic administration for all clinics were issued by PPGC's corporate officers in Houston, Texas. Relator has personal knowledge that these policies were issued company-wide to all clinics (not just

the Lufkin clinic). While present at various company meetings, Relator personally heard corporate officers, including Peter Durkin (President and CEO of PPGC), and Melanie Linton (Sr. VP of PPGC) expressly state that the policies and strategies complained of herein were being implemented at all PPGC clinics, not just the Lufkin Clinic.

23. Relator gained additional knowledge that the policies identified herein were company-wide practices through her participation in the monthly meetings at the Lufkin clinic. These local clinic meetings were always held within a few days after the monthly clinic directors meeting held in Houston. Each month during Relator's employment, PPGC held a clinic directors meeting in Houston that was attended by the director for each of PPGC's twelve clinics. According to statements made to Relator by Lufkin Clinic Directors Diana Wheeler, Michelle Green, and Regina Whittmann, at these Houston meetings the corporate officers of PPGC discussed revenue goals and revenue performance of each clinic and implemented the company-wide policy changes relating to services provided (including WHP, Medicaid, and Title XX services) and billing practices complained of herein, for the express purpose of maximizing revenues. Immediately following the monthly clinic directors meeting, the director of the Lufkin clinic (Wheeler, Green, or Whittmann) would then hold a clinic meeting and advise Relator (and her co-workers) of these company-wide policy changes issued by corporate. Again, it was made clear to Relator, through direct comments from Wheeler, Green, and Whittman that these revenue generating policies were applicable to all the PPGC clinics.

24. PPGC even utilized cross-training of employees whereby employees from "under-performing" clinics were sent to higher-performing clinics to train on methods of increasing revenue billed to state and federal health care programs. For example, PPGC corporate directors instructed

the Lufkin clinic to send Assistant Director Regina Wittmann to the Greenspoint Clinic in Houston for several days for training on how to increase the average “price per visit” for WHP, Medicaid, and Title XX patients. During this same period of time, the Lufkin clinic director, Michelle Green, urged employees to work hard to “get our price per visit up.” Each clinic had a daily “goal board” listing its daily billing goal to be accomplished. This “goal board” listed separate amounts the particular clinic was expected to bill daily for WHP patients, Medicaid patients, and Title XX patients. The memorandums and emails from corporate officers (including Durkin, Linton, Buster, McGill, and Smolenski) that were provided to Relator and discussed these company-wide policy changes and revenue goals were addressed to individuals at all of PPGC’s clinics.

25. Pursuant to PPGC’s corporate policies and procedures, as explained to Relator and her fellow employees by the Lufkin clinic directors and PPGC corporate officers, all PPGC health clinics were required to constantly increase their “pay-per-visit” revenue goals for medical services charged to government programs such as WHP, Medicaid, and Title XX. Extensive and ongoing training, as well as dynamic policy adjustments, were provided and implemented by PPGC corporate officers, including Peter Durkin, Melanie Linton, Laurie McGill, and Jeffrey Palmer, in order to ensure that all health clinics were constantly maximizing the financial payments received from said government programs, regardless of whether the services billed for were medically necessary or ever actually provided. Mr. Durkin and Ms. Linton traveled annually to each PPGC clinic to meet with the clinic’s employees and discuss the clinic’s performance for the prior year, as well as revenue strategies, forecasts, and budgets projected in the future. At these meetings, Durkin and Linton discussed, and depicted through Power Point presentations, these strategies and the financial needs and plans of the company. Durkin and Linton explained PPPG’s corporate scheme for maximizing

clinic profits through WHP, Medicaid, and Title XX grants and reimbursements. The scheme included the express policy of billing these government health care programs for a predetermined list of reimbursable services for every eligible patient who visited the clinic, regardless of whether those services were medically necessary or ever actually provided to the patient. Durkin and Linton circulated documentation to this effect but instructed that such documents either be returned to them or destroyed following the meeting.

Pre-determined Services Billed to Patients Regardless of Medical Necessity

26. During her employment, Relator learned that PPGC policy regarding which medical services to provide and bill for depended in large part on who was paying the bill. Pursuant to PPGC policy, self-pay patients were provided services based on medical necessity. WHP, Medicaid, and Title XX patients, however, were provided a series of predetermined services <u>based on what those programs would pay for</u> with the result that patients covered by government health programs were often provided services on an "across the board" basis even when such services were not medically necessary. The medical testing services most commonly provided to Medicaid and Title XX patients on an "across the board" basis, without regard to their medical necessity, are:

a) Gonorrhea testing (Codes 87590 and 87591);

b) Chlamydia testing (Codes 87490 and 87491);

c) HIV testing;

d) Syphilis testing;

e) urinalysis (Codes 81002 and 81015);

f) hemoglobin blood count testing (Code 85018); and,

g) pregnancy testing.

Relator regularly observed employees of the Lufkin clinic implementing the above policies and, as previously stated, personally heard both PPGC corporate directors and Lufkin clinic directors state that employees at the other PPGC clinics engaged in these practices.

Medical Services Charged, But Not Provided

27. Medicaid reimbursement guidelines allow reimbursement for counseling charges of one primary birth control method and multiple backup methods, if used by the patient. As a result, Defendant PPGC required its employees to bill for birth control method counseling and multiple backup method counseling for every visit by a Medicaid/WHP-eligible patient.

28. As a practical matter, many of Defendant's patients during Relator's tenure were long-term clients who used Defendant's clinics as their source for regular medical checkups and birth control medications. Relator observed that patients who, for example, were known by Defendant's employees to be in monogamous relationships, to have been using the same oral contraceptives for years, and to be well aware of how to use the medication, did not need or request repetitive birth control method counseling on every visit. More importantly, these patients were not provided the repetitive counseling for which PPGC policy required its employees to bill as to WHP/Medicaid patients. Throughout Relator's employment, Defendant PPGC's officers and directors instructed clinic personnel to bill the Texas and Federal government programs for birth control counseling as well as backup method birth control counseling whether or not the counseling services were medically indicated or actually provided.

29. During the course of her employment, Relator regularly observed that clinic personnel, operating pursuant to the above-described PPGC corporate policy, entered billing codes for having counseled a patient as to multiple birth control methods but did <u>not</u> actually counsel the

patient regarding the use of each method. Instead, Relator and other clinic personnel were instructed, through policies handed down by PPGC corporate officers including Durkin, Linton, and Wood and reiterated and enforced by local clinic directors including Wheeler and Green, that if they had a patient using a single method of birth control (*e.g.*, oral contraceptives or an I.U.D.), they should simply hand her a brown paper bag containing condoms and vaginal film as she was walking out the door. Almost all WHP/Medicaid patients were handed a bag of condoms and vaginal film despite the fact that the items were not needed or requested by the patient. Pursuant to PPGC corporate policy and instructions from clinic directors, after merely handing the patient a bag of condoms and vaginal film on the way out the door, clinic employees then entered billing codes to be submitted to the government for:

a. Condoms $4.20

b. Vaginal film $12.60

c. Method counseling $30.60 (Primary method, plus film and condoms as 'back-up' $10.20 X 3)

d. Problem counseling $10.45 (Under PPGC procedures, handing out condoms justified billing the government for 'problem counseling' because condoms are also used to prevent STD's) (Code 99402 + Modifier FP [$10.45])

Handing out unneeded and unrequested condoms and vaginal film to WHP/Medicaid patients as a pretext for billing unneeded and unprovided counseling services was one of the most common revenue increasing policies utilized by PPGC during Relator's employment.

Fraudulent Patient Chart Documentation to Obtain Reimbursement for Unqualified Services

30. Defendant PPGC also trained its employees to create fraudulent and misleading

patient chart entries so as to obtain reimbursement for services for which WHP and Medicaid would otherwise not allow payment. One notable example of this practice relates to PPGC policies for obtaining payment for abortion-related services. WHP, Medicaid, and some other government programs do not allow payment for abortion-related services including "follow-up visits" after an elective abortion procedure. The following is a direct quote from a staff meeting memorandum given to clinic employees January 22, 2009:

> POST AB VISITS:
> We must work these clients in! This visit is self-pay. Quote the self-pay price then ask if she needs any other services such as birth control. If she is interested, screen for WHP or Title XX and offer the WWE [Well Woman Exam]. If the client is getting on birth control *make this the focus of the visit* and put a note in the chief complaints that the client had a surgical or medical abortion "x" weeks ago.

(Emphasis added).

31. A second memorandum given to employees in February 2009, in preparation for a Department of State Health Services audit, was even more explicit in instructing employees on how to fraudulently bill WHP, Medicaid, and other government programs for post-abortion patient visits, including an express instruction to document in a patient chart that the reason for the patient's visit was to have the Well Woman Exam when in truth the patient had clearly indicated the purpose of the visit was a post-abortion follow-up.

> POST AB VISITS:
> On the telephone – if client requests post-ab check, tell her that service is a self-pay service and quote price. Ask if she wants other services during the visit – especially a birth control method. If yes, screen her for WHP or Title XX eligibility for the birth control part of the visit.
>
> Make sure that if the visit is being paid for by Title XX, Medicaid, or WHP that it is a <u>birth control focused</u> visit with a note in the subjective section that the client has an abortion "x" weeks ago. Example: Client here for WWE and to start on "x" BCM. States had surgical (or medical) abortion "x" weeks ago.

(Emphasis in original). During the time of Relator's employment with PPGC, clinic employees regularly complied with the above policy instructions, and claims for these unqualified services were ultimately billed to the government through the procedure outlined below in ¶ 34(i).

PPGC Procedure for Billing Government Programs for Medically Unnecessary Procedures And/Or Procedures Not Provided

32. As stated above, throughout the duration of Relator's employment with PPGC (1999 – 2009) and pursuant to company-wide policies explained by both PPGC corporate directors and local clinic directors, Relator observed clinic personnel entering WHP and Medicaid billing codes to obtain reimbursement for services that were (i) not actually rendered to patients, (ii) not medically necessary, and (iii) not covered by Medicaid. Employees entering such codes under the direction, instruction, and training of PPGC officers and directors include: Relator, Paola Carrizales, Laura McQueen, Suzy Briedenthall, Flo Jaramillo, Kelly Huffhines, Gloria Ivey, Verna McCarver, Kelly Madkins, Bonnie Smith, Della Connor, Sandra Smolenski, Diana Wheeler, Michelle Green, Regina Whittmann, and Kimberly Cottle.

33. Because of PPGC's corporate policy of maximizing its daily revenues, the decision about what services to provide patients was driven by what services the various government programs would pay for, as opposed to the medical necessity of the various procedures and tests. From Relator's experience, Defendant's scheme can be readily demonstrated by comparing the medical charts and billing records of self-pay patients to the charts and billing records of patients enrolled in government medical programs. Indeed, because of its "bill everything you can" corporate policies, PPGC was often able to bill government programs more than it charged self-pay patients for the same service. A comparison of the most common charges and services provided to patients, based on who was paying the bill rather than medical necessity, is set out in the table below:

Visit Type (or Chief Complaint)	Charges to Self-Pay Patient	Charges to Medicaid/Title XX
Patient requests pregnancy test only	Patient charged $25 flat fee	Government charged for • Office visit • Pregnancy test • Birth Control Method counseling (up to 4 methods) • Problem counseling
Breast Exam	Patient charged $36 flat fee	Government charged for • Office visit • Problem counseling • Pregnancy test (based on the premise that if a woman has a sore breast she may be pregnant – medical necessity would tie this test to a missed menstrual cycle)
Well Woman Exam	Patient charged for • Office visit • Pap Smear	Government charged for • Office visit • Pap smear • Urinalysis • Hemoglobin test • HIV test • Syphilis test • Gonorrhea test • Chlamydia test • Birth Control Method counseling (up to 4 methods) • Condoms & vaginal film • Problem counseling
H.O.P.E. visit (birth control only appointment)	Patient charged for • Office visit • Contraceptive medication	Government charged for • Office visit • Birth Control Method counseling (up to 4 methods) • Contraceptive medication • Condoms & vaginal film • Problem counseling

Vaginal Problems	Patient charged for • Office visit • Wet mount (swab test that the clinic uses to diagnose yeast infections, bacteria, etc.) • Only if the WM test is negative for bacteria or yeast infection, is the patient provided with additional diagnostic testing as medically necessary.	Government charged for • Office visit • Wet mount • Urinalysis • Hemoglobin test • HIV test • Gonorrhea test • Chlamydia test • Syphilis test • Birth Control Method counseling (up to 4 methods) • Problem counseling
Patient Requests STD Test	Patient charged for • Office visit • Specific STD test requested by patient	Government charged for • Office visit • HIV test • Gonorrhea test • Chlamydia test • Syphilis test • Birth Control Method counseling (up to 4 methods) • Problem counseling • Condoms and vaginal film

34. PPGC's office procedure for seeing patients was directed towards maximizing charges submitted to government programs, without regard to whether the service billed was necessary or ever actually provided. During Relator's employment, PPGC employees were trained to fill out the patient's bill *before* services were rendered. The procedure for a typical patient at PPGC clinics during the time of Relator's employment was as follows:

a. Patient's chart was pulled in advance, usually the day before a scheduled appointment and a new "super bill" (document listing all services available at the clinic) was placed in the chart;

b. On arrival, the patient first saw a Health Care Assistant (HCA), or sometimes a Nurse Practitioner;

c. Before any services were rendered, the HCA made charge entries on the super bill, including all charges for the standard pre-determined services PPGC typically provided for the class of patient being treated, regardless of medical necessity (*e.g.*, self pay, Medicaid, or Title XX);

d. In addition to pre-marking the super bill, the HCA often conducted testing and sometimes provided counseling;

e. The patient then proceeded to see the Nurse Practitioner;

f. The Nurse Practitioner provided medical services and marked the super bill for any additional services rendered (if not already pre-marked on the super bill);

g. The patient returned to the front desk for check-out. The patient was handed a bag of condoms and vaginal film and solicited to make a donation to Planned Parenthood. (Donations were solicited from all patients whether they were self-pay, Medicaid, or Title XX);

h. The receptionist, or HCA, then double checked the super bill and entered any charges which were not previously marked but which "should have been" marked according to PPGC policies, as described herein. [See table above.] PPGC staff were trained to enter charges on the super bill without any verification that the services had actually been provided. Specifically, instead of using the patient chart (which should document services actually rendered) to fill out the super bill, clinic staff were trained to bill automatically the pre-determined list of procedures and services based

on whether the patient was self-pay, Medicaid, or Title XX;

i. The receptionist, or HCA, then entered the super bill information into PPGC's billing software program. The receptionist, or HCA, then printed a receipt of charges (matching the super bill) that was saved in the patient's chart. The patient chart was then set aside for a "Chart Review" to be performed later. All patient super bills were placed together with the end of day reports. Each PPGC clinic created a "Batch" file for the day's billing that included the employee I.D. of the staff member entering billing for the day, Clinic I.D., and the date. On a weekly basis, Melanie Wood, in the PPGC corporate office, compiled all the billing of each clinic and submitted the billing to each government health care program (*e.g.*, WHP, Medicaid, and Title XX). Several clinics also billed under the Title X program for teens. If there were any changes or discrepancies between the billing codes initially entered into the PPGC system and the billing codes actually submitted to the government, Ms. Wood would communicate the reasons for the change to the individual clinic employee who had submitted the bill. Given the rarity of such communications from Ms. Wood, Relator can confirm that the majority of the fraudulent billing codes entered by clinic employees to PPGC's corporate billing system were indeed submitted to the government for payment. Likewise, each month, Ms. Wood emailed a Microsoft Excel revenue summary spreadsheet to each clinic. The spreadsheet showed every clinic's generated revenue from each source: WHP, Medicaid, Title XX, Title X, Self Pay, and Donations;

j. Chart Reviews: During the time of Relator's employment, PPGC's chart review

practice was one of the essential linchpins of its scheme to defraud government programs. As noted above, when the patient left the clinic after an appointment, her chart was not immediately re-filed but was instead set aside for a "chart review." Several days later, a staff member, usually an HCA, was assigned to perform a chart review prior to re-shelving the patient files. In performing this internal chart review, the staff member was instructed, pursuant to PPGC policy, to examine the charges on each super bill and compare them to the entries in the patient's medical chart. The stated purpose was to ensure that patient charts always supported the claims submitted to the government. In Relator's experience, approximately 1/3 of the patient files would contain charges on the super bill with no underlying documentation in the patient's chart to indicate the corresponding service was ever provided. When this occurred, instead of correcting the bill, the reviewer was instructed to take the chart to the HCA or nurse practitioner who handled the patient so that person could "fix" the chart to match the bill. Commonly, clinic employees were required to retroactively alter patient charts to reflect services that were never provided. In this manner, Defendant PPGC was able to evade detection of auditors because the chart would always match the claims submitted to the government.

35. According to statements and explanations Relator heard from PPGC corporate directors and local clinic directors, the above-described procedure, including pre-marking patient billing prior to services being rendered, based on whether the patient was self-pay or eligible for a government health care program, as well as the "Chart Review" process reconciling patient charts to the pre-determined bill, was a standard practice at PPGC clinics during the entire time of Relator's

employment with PPGC. Clinic personnel who entered medical billing codes without the presence of supporting documentation in the patient chart did so based exclusively on Defendant's corporate policy mandates as described herein. The "Chart Review" procedure was communicated to clinic employees, including Relator, by Lufkin clinic directors Wheeler and Green, who advised Relator and her fellow employees that this procedure was followed at all PPGC clinics.

36. PPGC presented false claims for reimbursement for the services described herein to the U.S. and Texas Governments as described above.

CAUSES OF ACTION

Count I

False Presentation of Claims for Services Not Rendered
(Federal False Claims Act)

37. Relator re-alleges and incorporates the allegations of paragraphs 1-36 as if fully set forth herein.

38. PPGC, through its officers, directors, and managers, repeatedly instructed and/or trained its employees to enter billing codes for medical services without any supporting documentation in the patient chart to indicate that those same services had actually been rendered.

39. PPGC had actual knowledge, acted in deliberate ignorance, or acted in reckless disregard for the truth, when it repeatedly submitted or caused the submission of claims to the U.S. Government with billing codes for medical services that were never actually provided.

40. PPGC then presented those false claims to the U.S. Government for payment.

41. This course of conduct violated the federal False Claims Act, 31 U.S.C. §§ 3729, *et seq*.

42. The U.S. Government, unaware of the falsity of the claims and/or statements made by PPGC, and in reliance on the accuracy thereof, awarded grants and/or payments to PPGC in the amount of several millions of dollars between July 30, 2003 and February 2009.

Count II

False Billings for Services Not Medically Necessary and Not Covered by Medicaid
(Federal False Claims Act)

43. Relator re-alleges and incorporates the allegations of paragraphs 1-36 as if fully set forth herein.

44. In order to maximize its profits generated from government health care programs, PPGC, through its officers, directors, and managers, repeatedly instructed and/or trained its employees to enter billing codes for medical services that were medically unnecessary, not requested by the patient, unwarranted, and not covered by Medicaid.

45. PPGC had actual knowledge, acted in deliberate ignorance, or acted in reckless disregard for the truth, when it repeatedly submitted or caused the submission of claims with billing codes for services that were either medically unnecessary or not covered by Medicaid.

46. PPGC then presented those false claims with illegitimate billing codes to the U.S. Government for payment.

47. This course of conduct violated the federal False Claims Act, 31 U.S.C. §§ 3729, *et seq*.

48. The U.S. Government, unaware of the falsity of the claims and/or statements made by PPGC, and in reliance on the accuracy thereof, awarded grants and/or payments to PPGC in the amount of several millions of dollars between July 30, 2003 and February 2009.

Count III

Falsifying Documentation Material to the Payment of Claims
(Federal False Claims Act)

49. Relator re-alleges and incorporates the allegations of paragraphs 1-36 as if fully set forth herein.

50. PPGC, through its officers, directors, and managers, repeatedly instructed and/or trained its personnel to alter information in patient charts to support billing codes submitted to the government for Medicaid reimbursement. The purpose of the creation of the fraudulent medical chart documentation was 1) to make it appear that certain services had been provided when, in fact, they had not and 2) to induce the government to approve Medicaid reimbursement claims submitted by Defendant.

51. The false information and statements created and maintained in PPGC's patient billing and medical charts were material to false claims for Medicaid reimbursement submitted by PPGC to the U.S. Government, and Defendant intended the Government to rely on such false information in approving claims submitted for Medicaid reimbursement.

52. This course of conduct violated the federal False Claims Act, 31 U.S.C. §§ 3729, *et seq*.

53. The U.S. Government, unaware of the falsity of the information underlying claims and/or statements made by PPGC for the purposes of receiving funding under the U.S. Medicaid program and in reliance on the material accuracy of such claims and/or statements, awarded grants and/or payments to PPGC in the amount of several millions of dollars between July 30, 2003 and February 2009.

Count IV

False Presentation of Claims for Services Not Rendered
(Texas Medicaid Fraud Prevention Act)

54. Relator re-alleges and incorporates the allegations of paragraphs 1-36 as if fully set forth herein.

55. PPGC, through its officers, directors, and managers, repeatedly instructed and/or trained its employees to enter billing codes for medical services without any supporting documentation in the patient chart to indicate that those same services had actually been rendered.

56. PPGC had actual knowledge, acted in deliberate ignorance, or acted in reckless disregard for the truth, when it repeatedly caused the submission of claims for medical services that were never actually provided.

57. PPGC then presented those false claims to the Texas Government for payment.

58. This course of conduct violated the Texas Medicaid Fraud Prevention Act, TEX. HUM. RES. CODE §§ 32.039, *et seq*., and 36.002, *et seq*.

59. The Texas Government, unaware of the falsity of the claims and/or statements made by PPGC, and in reliance on the accuracy thereof, awarded grants and/or payments to PPGC in the amount of several millions of dollars between July 30, 2005 and February 2009.

Count V

False Billings for Services Not Medically Necessary and Not Covered by Medicaid
(Texas Medicaid Fraud Prevention Act)

60. Relator re-alleges and incorporates the allegations of paragraphs 1-36 as if fully set forth herein.

61. In order to maximize its profits generated from government health care programs, PPGC, through its officers, directors, and managers, repeatedly instructed and/or trained its employees to enter billing codes for medical services that were medically unnecessary, not requested by the patient, unwarranted, and not covered by Medicaid.

62. PPGC had actual knowledge, acted in deliberate ignorance, or acted in reckless disregard for the truth, when it repeatedly caused the submission of claims for services that were either medically unnecessary or not covered by Medicaid.

63. PPGC then presented those false claims with illegitimate billing codes to the Texas Government for payment.

64. This course of conduct violated the Texas Medicaid Fraud Prevention Act, TEX. HUM. RES. CODE §§ 32.039, *et seq*., and 36.002, *et seq*.

65. The Texas Government, unaware of the falsity of the claims and/or statements made by PPGC, and in reliance on the accuracy thereof, awarded grants and/or payments to PPGC in the amount of several millions of dollars between July 30, 2005 and February 2009.

Count VI

Falsifying Documentation Material to the Payment of Claims
(Texas Medicaid Fraud Prevention Act)

66. Relator re-alleges and incorporates the allegations of paragraphs 1-36 as if fully set forth herein.

67. PPGC, through its officers, directors, and managers, repeatedly instructed and/or trained its personnel to alter the information in patient charts after submitting billing codes to the government for Medicaid reimbursement. The purpose of the fraudulent medical chart documentation was 1) to make it appear that certain services had been provided when, in fact, they had not and 2) to induce the government to approve Medicaid reimbursement claims submitted by Defendant.

68. The false information and statements created and maintained in PPGC's patient billing and medical charts were material to false claims for Medicaid reimbursement submitted by PPGC to the Texas Government, and Defendant intended the Government to rely on such false information in approving claims submitted for Medicaid reimbursement.

69. This course of conduct violated the Texas False Claims Act, TEX. HUM. RES. CODE §§ 32.039, *et seq*., and 36.002, *et seq*.

70. The Texas Government, unaware of the falsity of the information underlying claims and/or statements made by PPGC for the purposes of receiving funding under the Texas Medicaid program and in reliance on the material accuracy of such claims and/or statements, awarded grants and/or payments to PPGC in the amount of several millions of dollars between July 30, 2005 and February 2009.

PRAYER FOR RELIEF

WHEREFORE, Relator respectfully requests this Court to enter judgment against Defendant PPGC as follows:

(a) That the U.S. Government be awarded damages in the amount of three times the damages sustained by the U.S. because of the unlawful acts of Defendant complained of herein, as provided by the federal False Claims Act, 31 U.S.C. §§ 3729, *et seq.*;

(b) That civil penalties of $11,000 be imposed for each and every false claim that Defendant presented to the U.S. Government and/or its grantees;

(c) That the Texas Government be awarded damages in the amount of each payment provided to Defendant under the Medicaid program as a result of the unlawful acts complained of herein, plus two times the damages sustained by Texas because of such unlawful acts, as provided by the Texas False Claims Act, TEX. HUM. RES. CODE §§ 32.039, *et seq.*, and 36.052(a) and (b), *et seq.*;

(d) That civil penalties of $11,000 be imposed for each and every false claim that Defendant presented to the Texas Government and/or its grantees;

(e) That pre- and post-judgment interest be awarded along with reasonable attorney fees, costs, and expenses necessarily incurred by Relator and Plaintiffs in bringing and prosecuting this case;

(f) That the Court grant permanent injunctive relief to prevent any recurrence of the federal and state False Claims Act violations for which redress is sought in this Complaint;

(g) That Relator, Karen Reynolds, be awarded the maximum amount allowed to her pursuant to the federal False Claims Act and the Texas Medicaid Fraud Prevention Act; and

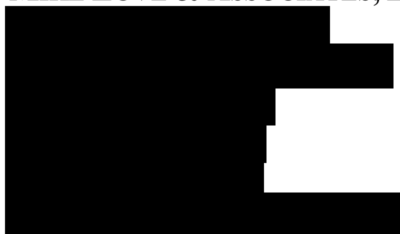
(h) That this Court award such other and further relief as it deems proper.

DEMAND FOR JURY TRIAL

Relator, on behalf of herself, the state of Texas, and the United States, demands a jury trial on all claims alleged herein.

Dated: October 28, 2011.

Respectfully submitted,

MIKE LOVE & ASSOCIATES, L.L.C.


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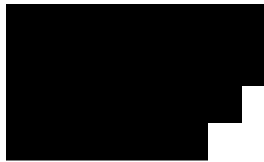

Larry L. Crain, Esq.
/s/ Carly F. Gammill
Carly F. Gammill, Esq.
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Attorneys for Relator

CERTIFICATE OF SERVICE

I certify that on October 28, 2011, a copy of the foregoing Response to Defendants' Motion to Dismiss Second Amended Complaint was electronically filed on the CM/ECF system, which will automatically serve a Notice of Electronic Filing on the following attorneys for Defendants Planned Parenthood Gulf Coast f/k/a Planned Parenthood of Houston and Southeast Texas, Inc., Planned Parenthood of Southeast Texas Surgical and Comprehensive Health Services, Inc., and Planned Parenthood of Houston and Southeast Texas Action Fund, Inc.:

KING & SPALDING LLP
Alissa B. Rubin

THE HEARTFIELD LAW FIRM
J. Thad Heartfield
M. Dru Montgomery

Electronic notice will also be provided to the following:

J Kevin McClendon
US Attorney's Office - Plano

Mark Coffee
Office of the Attorney General of Texas

/s/ Carly F. Gammill
Carly F. Gammill