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SCOTT G. WEBER, CLERK
CLARK COUNTY

STATE OF WASHINGTON
CLARK COUNTY SUPERIOR COURT

STATE OF WASHINGTON,

Plaintiff,

v.

CAREONE DENTAL
CORPORATION, LIEM DO, DDS,
PLLC, LIEM DUY DO, PHUONG-
OANH THUY TRAN, and their marital
community,

Defendants.

NO. **15-2-02514-1**

COMPLAINT FOR DAMAGES AND
CIVIL PENALTIES FOR MEDICAID
FRAUD

The State of Washington, by and through its attorneys, ROBERT W. FERGUSON, Attorney General, and WALTER M. SMITH, Assistant Attorney General, brings this civil action to recover all damages, penalties, and other remedies available from Defendants CareOne Dental Corporation, Liem Do, DDS, PLLC, Liem D. Do, and Phuong-Oanh T. Tran for their violations of the Medicaid Fraud False Claims Act, Chapter 74.66 RCW, the Medicaid Provider Fraudulent Practices Statute, RCW 74.09.210, and the common law.

I. NATURE OF THE CASE

1. Defendants Liem Do and Phuong-Oanh Tran, husband and wife, practice dentistry in the Vancouver, Washington area at CareOne Dental Corporation, and have been reimbursed by Washington's Medicaid program for providing dental care services from 2011 to the present, and in prior years as well. From at least January 1, 2011 to the present ("the

1 relevant time”), Defendants systematically billed the Medicaid program for non-covered
2 services such as Preventive Resin Restorations (CDT Code D1352), which they wrongfully
3 billed as Restorations (CDT codes D2000-2999); for surgical tooth extractions, where no
4 documentation suggests anything other than a routine extraction was performed; and for a
5 multitude of X-rays, patient encounters, and other dental procedures of which no
6 documentation exists whatsoever. As a result of Defendants’ fraudulent conduct in billing for
7 non-covered, upcoded, and undelivered services, they caused Medicaid to lose approximately
8 one million dollars, or more, through numerous false claims for dental services, and failed to
9 render the treatment Medicaid paid for needy Medicaid clients to receive—including pregnant
10 women, children, and the elderly.

11 2. Washington’s Medicaid program is a means-tested benefit program providing
12 healthcare coverage to low income children, pregnant women, families, persons with
13 disabilities, and elderly citizens. The Medicaid program was established pursuant to Title XIX
14 of the Social Security Act.¹ It is administered by the state and jointly funded on a matching
15 basis by the state and federal governments. So long as the state’s Medicaid program is
16 administered in compliance with federal requirements, the federal government pays a share of
17 the costs known as the Federal Medical Assistance Percentage.

18 3. Washington is required to prepare and receive approval from the federal
19 government for its State Medicaid Plan (State Plan). Washington’s State Plan, which was
20 approved by the federal government, defines eligibility criteria, client benefits, and provider
21 reimbursement rules. RCW 74.09.510; RCW 74.09.520.

22 4. The Medicaid-funded Apple Health dental benefit is administered by
23 Washington’s Single State Agency for Medicaid services, the Health Care Authority (HCA).

24 _____
25 ¹ Section 1903(a)(7) of the Medicaid Act; 42 C.F.R. § 430.1 *et seq.*; RCW 74.09.035. Statutes
26 authorizing and describing the operation of state Medicaid program are set forth in Chapter 74.09 RCW. Related
administrative rules are found, in large part, in Title 182 WAC.

1 As the Single State Agency, HCA has overall responsibility for administration of the State's
2 Medicaid dental program. Regulations of the Washington Medicaid dental program are
3 generally found at Chapter 182-535 WAC.

4 5. Under the Medicaid dental program, Medicaid beneficiaries (also sometimes
5 referred to as "clients" or "recipients") may choose to receive dental care services from a
6 dentist of their choice who meets eligibility criteria and executes a Core Provider Agreement.
7 The dental services payable under the Medicaid program and the applicable billing instructions
8 are defined in Chapter 182-535 WAC, the Dental Provider Guides issued from time to time by
9 HCA, and the fee schedules periodically published online by HCA. The Medicaid program
10 reimburses dental providers for services rendered to Medicaid clients according to the
11 requirements of federal and state law and the terms of the Core Provider Agreement. Providers
12 have the responsibility to accurately document and bill for the services they provide to
13 Medicaid clients, as the Medicaid program processes a large volume of claims, and generally
14 lacks the time or resources to verify claims prior to paying them.

15 6. Defendants CareOne Dental Corporation and Liem Do, DDS, PLLC
16 (collectively "CareOne"), both business entities organized in the State of Washington, entered
17 into Core Provider Agreements with the State of Washington and, during the period January 1,
18 2011 to present, and in previous years, were reimbursed for providing dental services to
19 thousands of Medicaid clients in the Vancouver, Washington area.² Over the same time period,
20 CareOne operated four dental clinics in Washington and two in Oregon. In addition to Dr. Do
21 and Dr. Tran, several other dentists worked at CareOne; CareOne obtained payment from
22 Medicaid for those providers' services by listing the name of the practice as the "servicing
23

24 ² Liem Do, DDS, PLLC, d/b/a Comfort Dental, was the business entity used by Dr. Do to bill Medicaid
25 for dental services prior to approximately July 2012, when he transitioned to using a new entity, CareOne Dental
26 Corporation, for his dental practice. The ownership structure, providers, clinic locations, and billing practices of
Liem Do, DDS, PLLC and CareOne Dental Corporation are indistinguishable and therefore for convenience the
entities are referred to collectively as "CareOne."

1 provider,” “billing provider,” or both, on the providers’ reimbursement claims. Liem Do is the
2 sole corporate officer and shareholder of CareOne Dental Corporation and the sole member of
3 Liem Do, DDS, PLLC. CareOne lacks a compliance program, does not employ a Dental
4 Director, and does not conduct chart audits to verify the accuracy of claims submissions or of
5 documentation of services rendered to Medicaid clients or other patients. Numerous claims for
6 non-covered and/or non-provided services were submitted to Medicaid by CareOne between
7 January 1, 2011 and the present.

8 7. Defendant Liem Duy Do (“Dr. Do”) is a Doctor of Dental Surgery and has been
9 a licensed dentist in the State of Washington since June 9, 1998. Dr. Do has owned and
10 managed his own dental practice in Vancouver, Washington since 2004, originally known as
11 “Comfort Dental,” and more recently known as CareOne Dental Corporation. Dr. Do has
12 served as a Medicaid dental provider throughout his entire career as a dentist, first in the State
13 of Minnesota and more recently in Washington. Over his career, Dr. Do has supervised
14 numerous dentists, dental hygienists, dental assistants, and dental billers involved in providing
15 and billing for services to Washington Medicaid clients. Dr. Do has remained intimately
16 involved with his practice’s Medicaid billing and reimbursement process for many years, by
17 reviewing claims entered by CareOne’s billing staff in the PracticeWorks software “ledger” on
18 a daily basis, editing claims prior to submission, and causing denied claims to be resubmitted.
19 Over 99% of the claims for services provided at CareOne in the relevant time were submitted
20 to Medicaid with Dr. Do’s name or his company’s name (Comfort Dental) listed as the
21 “servicing provider.”

22 8. Defendant Phuong-Oanh Tran (“Dr. Tran”) is a Doctor of Medical Dentistry
23 and has been a licensed dentist in the State of Washington since March 4, 2010. Dr. Tran has
24 treated Medicaid clients at CareOne Dental Corporation or its predecessor entity, Comfort
25 Dental, throughout her career as a dentist. Dr. Tran is married to Dr. Do. Dr. Tran has caused
26

1 numerous false claims to be submitted to Medicaid for services not provided and/or non-
2 Medicaid covered procedures such as Preventive Resin Restorations.

3 **II. JURISDICTION AND VENUE**

4 9. The State of Washington brings this action pursuant to RCW 74.09.210, RCW
5 74.66.040, RCW 43.10.030(2), and the common law.

6 10. This Court has personal jurisdiction over Defendants because Defendants
7 reside in Clark County, Washington.

8 11. Venue is proper in this Court pursuant to RCW 74.66.110(1). Defendants reside
9 in Clark County and transact business there, and the actions complained of in this Complaint
10 took place in Clark County.

11 **III. PARTIES**

12 12. The State of Washington brings this action by and through the Attorney General
13 under its statutory powers (RCW 74.66.040 and 74.09.210) and in its sovereign capacity on
14 behalf of the Washington Medicaid program to recover Medicaid funds that should not have
15 been paid, related civil penalties, pre-judgment interest, investigation and litigation costs, and
16 other appropriate relief. The Medicaid Fraud Control Unit (MFCU) of the Attorney General's
17 Office investigates and prosecutes fraud or false claims affecting Washington's Medicaid
18 program.

19 13. The allegations contained in this Complaint are based upon an investigation
20 conducted by the Medicaid Fraud Control Unit of the Washington State Attorney General's
21 Office. At all times material to this action, the State of Washington acted through its Medicaid
22 Fraud Control Unit (MFCU) and the Health Care Authority (HCA). HCA manages the
23 Washington Medicaid Apple Health dental benefit, including processing of claims for
24 payment, and is located at 626 8th Ave SE, Olympia, WA 98501. The State Treasurer paid the
25 claims submitted by Defendants, and is located at 416 Sid Snyder Avenue SW in Olympia,
26 Washington.

1 14. Defendant Liem Duy Do resided in Clark County, Washington at all times
2 material to this action. Since 1998, Medicaid has paid Dr. Do for providing dental care services
3 to Medicaid clients through the Apple Health dental benefit program and other programs.

4 15. Defendant Phuong-Oanh Thuy Tran resided in Clark County, Washington at all
5 times material to this action. Since 2010, Medicaid has paid Dr. Tran for providing dental care
6 services to Medicaid clients through the Apple Health dental benefit program and other
7 programs.

8 **IV. FACTUAL ALLEGATIONS**

9 16. Dentistry is regulated by the Washington State Dental Quality Assurance
10 Commission (Commission) in the State of Washington. RCW 18.32.0365. In addition to their
11 educational qualifications and training, all dentists must obtain a license from the State in order
12 to practice dentistry. Rules governing the professional conduct of dentists and corresponding
13 administrative procedures promulgated by the Commission are set forth in statutes such as
14 RCW 18.32 *et seq.*, RCW 18.130 *et seq.*, and in Chapter 246-817 WAC. Among other things, a
15 dentist is required to maintain complete records of all treatment he or she provided to patients,
16 including X-rays, treatment plans, patient charts, billing records, and “a comprehensive written
17 and dated record of all services rendered to his/her patients.” WAC 246-817-310. Dentists are
18 forbidden to “represent the care being rendered to their patients or the fees being charged for
19 providing such care in a false or misleading manner, nor [may they] alter patient records, such
20 as but not limited to, misrepresenting dates of service or treatment codes.” WAC 246-817-390.
21 Moreover, as noted below in paragraph 18, dentists, like the defendants here, agree to abide by
22 federal and state laws.

23 17. Dental providers like dentists and hygienists use a uniform system to describe
24 treatments provided to patients, known as the Current Dental Terminology (CDT) codes
25 published by the American Dental Association. CDT codes are universally recognized among
26 dental providers, are taught in dental schools and training programs for dental professionals,

1 are publicly searchable on the internet and in printed media, and are used for billing purposes
2 to describe the precise nature of each service performed. The HCA's Dental Services Provider
3 Guides (which require providers to use CDT codes when submitting bills) and published fee
4 schedules list procedures and the corresponding CDT code.

5 18. To receive reimbursement for providing dental care services to Medicaid
6 clients, an applicant must sign a contract outlining his or her responsibilities as a health care
7 provider. Defendant Dr. Do signed a Core Provider Agreement ("CPA") on behalf of his
8 business entity Comfort Dental on April 2, 2004; CareOne Dental Corporation, represented by
9 Office Manager Karyn Haller, signed a CPA containing identical language on June 17, 2012.
10 Both CPAs remained in effect throughout the time material to this Complaint. Both agreements
11 have the exact same language as it relates to the provider's obligations. By signing the CPA,
12 Defendant CareOne agreed to the following terms:

- 13 • "The Provider is subject to and shall comply with all federal and state laws, rules,
14 and regulations and all program policy provisions, including department numbered
15 memoranda, billing instructions, and other associated written department issuances
16 in effect at the time the service is rendered, which are incorporated into this
17 Agreement by this reference." CPA 1, ¶ 1.
- 18 • "**Billing and Payment.** The Provider Agrees: a. To submit claims for services
19 rendered to eligible clients, as identified by the department, in accordance with
20 rules and billing instructions in effect at the time the service is rendered." *Id.*, ¶
21 3(a).
- 22 • "The Provider Agrees: ... b. To accept as sole and complete remuneration the
23 amount paid in accordance with the reimbursement rate for services covered under
24 the program, except where payment by the client is authorized by applicable
25 WAC." *Id.*, ¶ 3(b).

- 1 • **“Inspection; Maintenance of Records.** For six (6) years from the date of services,
2 or longer if required specifically by law, the Provider shall: a. Keep complete and
3 accurate medical and fiscal records that fully justify and disclose the extent of the
4 services or items furnished and claims submitted to the department.” *Id.* at 2, ¶ 5(a).
- 5 • “The Provider shall make available upon request appropriate documentation,
6 including client records, supporting material, and any information regarding
7 payments claimed by the Provider, for review by the professional staff within the
8 department or the Secretary of the U.S. Department of Health and Human Services.
9 The Provider understands that failure to submit or failure to retain adequate
10 documentation for services billed to the department may result in recovery of
11 payments for medical services not adequately documented, and may result in the
12 termination or suspension of the Provider from participation in the medical
13 assistance and medical care programs.” *Id.*, ¶ 5(b).
- 14 • **“Audit or Investigation.** Audits or investigation may be conducted to determine
15 compliance with the rules and regulations of the program. If an audit or
16 investigation is initiated, the Provider shall retain all original records and supportive
17 materials until the audit is completed and all issues are resolved even if the period
18 of retention extends beyond the required 6 year period.” *Id.*, ¶ 6.
- 19 • **“Certification.** This is to certify that the information provided in support of this
20 agreement is true and accurate and I completely understand that any falsification or
21 concealment of a material fact may be prosecuted under Federal and State Laws....
22 I agree to abide by the terms of this Agreement including all applicable federal and
23 state statutes, rules, and policies.” *Id.* at 3, ¶ 15.

24 19. As of April 2, 2004, CareOne and its sole shareholder and officer, Dr. Do, each
25 knew that they were required to comply with the dental practice standards of Chapter 246-817
26 WAC, and that they were to bill the Medicaid program only in accordance with published

1 billing instructions and the rules and regulations in Chapter 182-535 WAC.³ Defendants
2 CareOne and Dr. Do also knew that they were to accept the Medicaid program's
3 reimbursement amount as payment in full for all covered services, except as specifically
4 authorized by the Washington Administrative Code provisions regarding billing Medicaid
5 clients directly; and that they were to retain all records of patient treatment for a minimum of
6 six (6) years (and longer in the event of an audit or investigation). Defendants CareOne and Dr.
7 Do knew that failing to properly document or retain documentation of the services billed to
8 Medicaid could result in financial recovery by the government and suspension or termination
9 of CareOne's status as a Medicaid provider.

10 20. Throughout the relevant time period, Defendants CareOne and Dr. Do billed the
11 Washington Medicaid program for dental services using paper claim forms and via electronic
12 submission through the ProviderOne billing portal. Over 99% of the claims billed to Medicaid
13 during the relevant time that were rendered by the providers at CareOne were submitted with
14 the name of Dr. Do's company, Comfort Dental, or Dr. Do's own name listed as the "servicing
15 provider" on the claim.

16 **CareOne Dental Billing Process**

17 21. Each of CareOne's four Washington offices prepared claims for billing to
18 Medicaid and other payors through a "superbill" system. After a dentist saw a patient, he or she
19 would complete a superbill by circling the exact Current Dental Terminology (CDT) codes

20 ³ While they are also explained in the HCA Provider Guides, the conditions of payment for Medicaid
21 dental services are listed in WAC 182-535-1079(1): "The agency pays for dental-related services and procedures
22 provided to eligible clients when the services and procedures:

- 23 (a) Are part of the client's dental benefit package;
- 24 (b) Are within the scope of an eligible client's Washington apple health (WAH) program;
- 25 (c) Are medically necessary;
- 26 (d) Meet the agency's prior authorization requirements, if any;
- (e) Are documented in the client's record in accordance with chapter 182-502 WAC;
- (f) Are within accepted dental or medical practice standards;
- (g) Are consistent with a diagnosis of dental disease or condition;
- (h) Are reasonable in amount and duration of care, treatment, or service; and
- (i) Are listed as covered in the agency's rules and published billing instructions and fee schedules."

1 corresponding to the treatment provided on a form provided by CareOne, circling his or her
2 name and noting the date of service, and adding any billing notes. For example, if the provider
3 completed simple extractions of teeth numbers 16 and 30, she would circle the CDT code on
4 the superbill "D7140" (extraction, erupted tooth or exposed root [elevation and/or forceps
5 removal]) and write "16, 30" next to the code. The provider would then deliver the completed
6 superbill to the receptionist at the front desk, who enters the information on the superbill
7 directly into the "ledger" in CareOne's PracticeWorks software system.

8 22. For the remainder of the day when a claim was first entered into the ledger, it
9 was possible for anyone at CareOne with access to the ledger to edit the details of the claim,
10 without any audit trail or indication that the original entry was altered. Instead, an altered claim
11 appeared as though it had originally been entered that way. However, the day after a claim was
12 first entered into the ledger, it would appear as "final" in the ledger, meaning that any
13 subsequent alteration would cause the claim text to turn from black to red within
14 PracticeWorks. Generally the provider handed up a completed superbill and the billing staff
15 keyed in claims data to the ledger on the same day when treatment was rendered. However, the
16 claims were not submitted to Medicaid for payment until at least one day later, so that Dr. Do
17 would have time to review and edit the claims data in the ledger at the end of the workday in
18 which the "service" was provided.

19 23. CareOne's billing staff such as receptionists or Office Managers did not
20 exercise discretion in assigning CDT codes to the treatment rendered to Medicaid clients.
21 Instead, their job was rote transcription of data in the provider's superbill directly into
22 PracticeWorks' "ledger" pane. Moreover, billing staff lacked certifications in medical or dental
23 coding, and were not trained to read progress notes or to assign corresponding CDT coding to
24 dental procedures. Most of the billing staff were in their early twenties and lacked formal
25 training or prior experience working in dental or medical billing.

26

1 24. At the end of each day, Defendant Dr. Do reviewed the ledger items keyed into
2 the billing system by his billing staff. If an improper claim had been typed in the ledger,
3 perhaps by mistake, Dr. Do could have corrected it. Instead, he would often change the ledger
4 in order to add additional line items to the reimbursement claim that were not supported by the
5 documentation for the services rendered, or to substitute a more lucrative billing item for what
6 was actually done.

7 25. *Example.* Medicaid Client A saw Dr. CB at CareOne on December 12, 2013.
8 Progress notes show that Dr. CB prepped the patient's teeth and added Embrace Wetbond
9 Sealant to #4, 5, 12, 13, 19, 21, 28, and 29. Dr. CB used no local anesthetic on Client A
10 according to her notes. Dr. CB completed a superbill including "Sealant" (CDT code D1351)
11 for these teeth, and receptionist Lyoda added sealants to the PracticeWorks ledger on the same
12 date. However, CareOne billed Medicaid for eight occlusal composite restorations for Client A
13 (CDT code D2391) on the same teeth, with Dr. Do listed as the servicing provider. Dr. Do
14 altered the data after it was entered in the PracticeWorks ledger, causing restorations to be
15 billed, so that he could collect more money on the claim. The claim should have paid out in the
16 amount of \$175.84, but Medicaid paid \$399.76 due to the misrepresentation.

17 **Dental Restorations Wrongfully Billed to Medicaid**

18 26. A dental restoration (or "filling") procedure is payable under Medicaid when it
19 is performed on decay extending *all the way* through the tooth's enamel—also known as dental
20 *caries*. WAC 182-535-1050 (caries must extend "through the enamel" or involve decay of root
21 surface); WAC 182-535-1100(2)(c)(i) (restorations not billable if decay does not penetrate
22 through the enamel). CDT codes D2000-D2999 are billable for procedures that are medically
23 necessary to restore dental caries.

24 27. Dr. Do has a practice of diagnosing dental caries where only superficial decay is
25 present, in violation of the Medicaid program's definitions of "restorations" and "caries" as
26

1 listed in WAC dental services regulations and the HCA's Provider Guides. At deposition, Dr.
2 Do admitted he restored decay when it was "two thirds" of the way through the enamel.

3 28. In many instances, restorations Dr. Do billed to Medicaid were not reimbursable
4 because any decay that was present did not penetrate all the way through the enamel at the time
5 the restoration was billed. Often, patient X-rays do not support the diagnosis of caries where
6 "restorations" were performed and/or billed. "Restorations" on teeth lacking decay that extends
7 fully through the enamel are not medically necessary.

8 29. Providers are required to maintain documentation describing medical necessity
9 and services rendered. A failure to document indicates that the services were not actually
10 provided. Some restorations billed to the Medicaid program by Dr. Do and other providers at
11 CareOne lack necessary documentation, radiographic evidence of decay through the tooth
12 enamel, or a diagnosis of caries on the tooth in question. As a result, such restorations did not
13 meet the conditions of payment of the Medicaid program. WAC 182-535-1071(1)(c), (g).

14 30. Defendants Dr. Do and Dr. Tran systematically caused Medicaid to be billed for
15 restorations (using the CDT D2000-2999 codes) in circumstances where the only services
16 provided were preventive—and therefore not reimbursable. These non-billable services include
17 sealants for adult patients and Preventive Resin Restorations (CDT code 1352, not payable per
18 Medicaid fee schedule). WAC 182-535-1100(2)(b)(iii) (sealants not reimbursable if tooth has
19 occlusal decay), (c)(ii) (preventive restorations not reimbursable). Former CareOne dentists
20 state that staff billed all dental sealants for adult patients as restorations at Dr. Do's instruction.
21 Additionally, Preventative Resin Restorations (PRRs) noted in patient charts were repeatedly
22 billed to Medicaid as "restorations" (using the CDT D2000-2999 codes) and deposition
23 testimony of CareOne's Office Manager, MD, shows that Dr. Do instructed staff to bill PRRs
24 and sealants as one-surface occlusal "restorations."

25 31. *Example.* Medicaid Client B saw Dr. Do on December 2, 2011. Progress notes
26 state "slight pit & fissure decay" and "full mouth Prr;" "no LA [local anesthetic]." There is no

1 diagnosis of dental caries extending fully through the enamel. The handwritten exam notes
2 from that day include the letter “P” written over five teeth where normally the carious surfaces
3 would be shaded in. CareOne submitted claims for dental restorations for the same five teeth.
4 The claim for \$913.00 was submitted to Medicaid on December 6, 2011 listing “Comfort
5 Dental” as the servicing provider, and Medicaid paid the claim in the amount of \$285.85. If the
6 claim had been billed properly under CDT code D1352, it would not have been paid.

7 32. *Example.* Medicaid Client C saw Dr. Tran on October 31, 2013. Progress notes
8 state “slight cavity” on 10 teeth and “deep grooves” on 6 teeth, with no particular surfaces
9 noted on any teeth. There is no documentation of dental caries extending fully through the
10 enamel, and no evidence anesthetic was used. An informed consent form signed by the patient
11 says 13 teeth would be restored. Medicaid was billed for 17 restorations. The claim for
12 \$3,023.00 was submitted to Medicaid on November 3, 2013 listing Liem Do as the servicing
13 provider, and Medicaid paid the claim in the amount of \$964.29. If the claim had been billed
14 properly under CDT code D1352, it would not have been paid.

15 33. *Example.* Medicaid Client D was seen at Comfort Dental on July 7, 2011 for
16 “restorative tx” although no diagnosis of caries on any particular tooth surface is mentioned in
17 progress notes, and only two teeth are noted as treated in the handwritten clinical examination
18 notes; four restorations are billed to Medicaid. No X-rays exist for this patient until 2013.
19 Claims for four restorations (that lack documentation of dental necessity/caries) were
20 submitted to Medicaid in the total amount of \$834.00 on July 8, 2011, with Comfort Dental
21 listed as the servicing provider; Medicaid paid \$263.86.

22 Extractions Upcoded from “Simple” to “Surgical”

23 34. In contrast with a simple tooth extraction, a surgical extraction involves “cutting
24 of the gingiva and bone,” WAC 182-535-1050, requires an incision into the gums (a “flap”),
25 and sometimes involves sectioning a tooth with a tool like a bur (cutter) prior to removing the
26 pieces with an open flap.

1 35. At Dr. Do's direction and with his knowledge, CareOne systematically billed
2 Medicaid for surgical extractions where only a simple extraction was provided—if any tooth
3 was extracted at all. Dr. JF, a former CareOne dentist, relates that Dr. Do informed him that
4 “[a]t CareOne all extractions are surgical.” Other former CareOne providers indicate that
5 upcoding extractions was an ingrained practice at CareOne. Dr. JG explained that Do “would
6 change stuff” from what she coded when she performed a procedure, for example, Dr. Do
7 upcoded simple extractions to surgical extractions.

8 36. *Example.* Medicaid Client E apparently had tooth #16 extracted on January 19,
9 2013. Progress notes give no indication that a bur was used, a flap was created, the tooth was
10 sectioned, or that bone was removed. A surgical extraction (CDT 7210) was billed to Medicaid
11 (apparently CDT code 7140 should have been billed, with allowed amount at \$30.49). The
12 claim for \$265.00 was submitted to Medicaid on January 23, 2013 listing Liem Do as the
13 servicing provider, and Medicaid paid the claim in the amount of \$59.80.

14 37. *Example.* Medicaid Client F apparently had tooth #17 extracted by Dr. LO on
15 October 24, 2011, and had tooth #15 extracted on June 27, 2013. Progress notes show the
16 procedures were done with elevator, luxator, and forceps – not a bur; there is no evidence a
17 flap was created, the tooth was sectioned, or that bone was removed. Surgical extractions were
18 billed to Medicaid. Two claims for \$225.00 and \$265.00, respectively, were submitted to
19 Medicaid on March 16, 2012, and June 28, 2013, listing Comfort Dental and CareOne Dental
20 as the respective billing providers, and Medicaid paid each claim in the amount of \$59.80.

21 **Improper Billing for Emergency Exams and Palliative Care**

22 38. A Limited Oral Evaluation (LOE) is a targeted patient evaluation relating to a
23 new problem, typically billed for “a dental emergency, such as trauma or acute infection.”
24 WAC 182-535-1050. Palliative Treatment is a minor procedure done to alleviate the patient's
25 pain or discomfort, rather than treating the underlying cause. Palliative treatment is billed
26 under CDT code D9110.

1 39. CareOne has a pattern of billing the “LOE” and D9110 codes when a patient is
2 merely following up after a recent procedure (follow up procedures are not reimbursable
3 because the encounter was already paid for in the cost of the original procedure); when the
4 patient does not complain of pain, discomfort, or otherwise have an emergency; when a patient
5 comes in for scheduled appointments, such as annual visits; or when the patient fails to appear.
6 *See* WAC 182-535-1100(2)(k)(ii)(M) (no-show, cancelled, or late arrival visits are not billable
7 to Medicaid). According to Office Manager MD’s deposition testimony, these line items were
8 used to compensate for revenue lost on non-covered services provided by CareOne, or services
9 requiring a prior authorization that CareOne could not or did not obtain.

10 40. *Example.* Medicaid Client G saw Dr. LO on November 1, 2012 and November
11 20, 2012 for occlusal adjustments secondary to restorations Dr. LO performed October 26,
12 2012. No evidence of an emergency is noted in the file, and no X-rays were taken on either
13 date. Medicaid was billed for Limited Oral Evaluations for both encounters. Two claims for
14 \$60.00 each were submitted to Medicaid on November 7 and November 30, 2012,
15 respectively, listing Liem Do as the servicing provider, and Medicaid paid each claim in the
16 amount of \$18.40.

17 41. *Example.* Medicaid Client H saw Dr. Tran on August 23, 2011. No progress
18 notes or record of what services were rendered exist aside from one X-ray with the same date.
19 Medicaid was billed for a Limited Oral Evaluation and Palliative Treatment. The claim
20 including \$207.00 for these items was submitted to Medicaid on August 29, 2012, listing Liem
21 Do as the servicing provider, and Medicaid paid for these items in the total amount of \$59.80.

22 42. *Example.* Medicaid Client H saw Dr. Tran on May 17, 2013. Four apparent
23 restorations were added to Client H’s handwritten treatment plan (#K–MO; #L–DO; #19–O;
24 #30–O) although no caries were noted in the “problem” column; each of these teeth had
25 already been restored in the previous two years at Medicaid’s expense, and therefore a claim
26 for a restoration on these teeth would have been rejected. The number “9110” was added by

1 hand to the right of each of the restorations in the treatment plan. In each of the following two
2 purported encounters, Dr. Do's progress notes state "fillings" were done on #19 and #30 on
3 May 20 and May 28, 2013, respectively, yet Medicaid was billed for a Limited Oral
4 Evaluation, Palliative Treatment, and a single periapical X-ray each date. No documentation of
5 the X-rays exists, nor is there evidence of procedures done to alleviate pain as opposed to its
6 underlying cause, nor were these encounters unplanned. Two claims totaling \$458.00 for these
7 items were submitted to Medicaid on May 22 and May 30, 2013, listing Liem Do as the
8 servicing provider, and Medicaid paid for these items in the total amount of \$144.48.

9 **Billing for Undocumented Services**

10 43. Dentists are required to keep "complete treatment records regarding patients
11 treated," including but not limited to "X-rays, treatment plans, patient charts, patient histories,
12 correspondence, financial data and billing." WAC 246-817-310. Many patient files from
13 CareOne do not have supporting X-rays, treatment plans, handwritten charts, patient progress
14 notes or other required documentation of services performed. As a result, the Medicaid
15 program's conditions of payment were violated as to the corresponding claims.

16 44. Restorations, extractions, and other services billed to the Medicaid program by
17 Dr. Do and other providers at CareOne often lack documentation to support that the procedure
18 was performed. For example, some patients' restorations were billed despite a lack of evidence
19 of the key steps of the procedure such as achieving anesthesia; prepping the teeth; excavating
20 decay and packing composite or placing amalgam; and curing the restorations, if necessary. In
21 some instances, radiographs taken after a procedure demonstrate that the procedure was not
22 actually performed. To the extent billings were submitted for services that were not performed,
23 the Medicaid program's conditions of payment were violated as to these claims.

24 45. *Example.* Medicaid Client H saw Dr. Do on May 20, 2013. Dr. Do noted that
25 tooth #10 was fractured due to gross decay. No X-ray exists for this day, although one was
26 billed to Medicaid. Medicaid was billed for a surgical extraction of #10. The X-ray claim was

1 submitted to Medicaid in the amount of \$22.00 on May 22, 2013, with Liem Do listed as the
2 servicing provider; Medicaid paid \$6.44 for the X-ray.

3 46. *Example.* Medicaid Client I saw Dr. SD on March 13, 2014. Progress notes state
4 "Root tip simple Extractions" for five teeth, and "14 surgical ext." One of the teeth extracted
5 per the progress notes does not match the tooth billed. No documentation in the patient chart
6 exists showing that a flap was created, that any tooth was sectioned, or that bone was removed.
7 A claim for five surgical extractions (CDT code 7210) was submitted to Medicaid in the
8 amount of \$1,325.00 on March 14, 2014, with Liem Do listed as the servicing provider;
9 Medicaid paid \$299.00.

10 47. *Example.* Medicaid Client J was seen on July 6, 2011; although Medicaid was
11 billed for four X-rays, none exist. On August 23, 2011, four amalgam restorations are billed to
12 Medicaid but no progress notes exist. No X-rays exist in the file until 2013. Claims for four X-
13 rays (that are missing from the patient's file) were submitted to Medicaid in the total amount of
14 \$77.00 on July 8 and 19, 2011, with Liem Do/Comfort Dental listed as the servicing provider;
15 Medicaid paid \$20.58. Claims for four restorations (that lack documentation of service being
16 rendered) were submitted to Medicaid in the total amount of \$760.00 on August 24, 2011, with
17 Comfort Dental listed as the servicing provider; Medicaid paid \$263.86.

18 **Defendants' Billing Schemes Summarized**

19 48. From January 1, 2011 through June 19, 2015, CareOne obtained payment from
20 Washington Medicaid for 138,730 claims in the total amount of \$5,049,176.98. Over 99% of
21 the claims were submitted with either Dr. Do or his business entity, Comfort Dental, listed as
22 the servicing provider. The schemes described above affect a significant portion of CareOne's
23 billings for restorations, extractions, and emergency visits, among other procedures.

24 49. As a result of the schemes described above, the Washington Medicaid program
25 sustained damages totaling approximately one million dollars, if not more, by paying CareOne
26 for non-covered services, upcoded services, services that were never performed, or services

1 that are not properly documented. Each of these types of claims violates the conditions of
2 payment of the Washington Medicaid dental program, and would not have been paid but for
3 Defendants' misrepresentations of the services actually performed.

4 50. Defendants had knowledge at the time when the fraudulent claims were
5 submitted during the relevant time that the services they were billing for were non-covered,
6 upcoded, or undocumented, and/or were never performed. The magnitude of the false claims
7 presented by Defendants and paid by Medicaid will be proven at trial, although an initial
8 comparison of a sample of patient records with billing claims suggests that at least 20% of the
9 claims presented by Defendants in the relevant time, and the dollars paid to them by Medicaid,
10 were a result of fraud. Accordingly, the single damages attributable to Defendants' fraud in the
11 relevant time period are estimated to total at least \$1 million.

12 V. APPLICABLE LAW

13 A. Conditions of Payment for Dental-Related Services, Chapter 182-535 WAC

14 51. In order to earn reimbursement from Medicaid, a dental care provider must
15 comply with state and federal law. Under the relevant regulations, "The agency pays for
16 dental-related services and procedures provided to eligible clients when the services and
17 procedures:

- 18 (a) Are part of the client's dental benefit package;
- 19 (b) Are within the scope of an eligible client's Washington apple health (WAH)
program;
- 20 (c) Are medically necessary;
- 21 (d) Meet the agency's prior authorization requirements, if any;
- 22 (e) Are documented in the client's record in accordance with chapter 182-502 WAC;
- 23 (f) Are within accepted dental or medical practice standards;
- 24 (g) Are consistent with a diagnosis of dental disease or condition;
- 25 (h) Are reasonable in amount and duration of care, treatment, or service; and
- 26 (i) Are listed as covered in the agency's rules and published billing instructions and fee
schedules."

WAC 182-535-1079(1). The purpose of these regulations is to describe the conditions for
obtaining payment from Medicaid.

1 **B. Anti-fraud provisions of the Medicaid Statute, Ch. 74.09 RCW**

2 52. The anti-fraud provisions of the Washington Medicaid Fraudulent Practices
3 statute prohibit a person or entity from obtaining or attempting to obtain Medicaid payments in
4 a greater amount than they are entitled to receive by means of: (a) willful false statement; (b)
5 willful misrepresentation, or by concealment of any material facts; or (c) other fraudulent
6 scheme or device, including but not limited to billing for services not provided. RCW
7 74.09.210(1).

8 53. Any person or entity that knowingly violates any of the provisions of RCW
9 74.09.210(1) “shall be liable for repayment of any excess benefits or payments received, plus
10 interest in the manner provided in RCW 43.20B.695.” Further and in addition, such person or
11 entity is subject to civil penalties “in an amount not to exceed three times the amount of such
12 excess benefits or payments.” RCW 74.09.210(2).

13 **C. The Washington Medicaid Fraud False Claims Act, Ch. 74.66 RCW**

14 54. The Washington Medicaid Fraud False Claims Act, Chapter 74.66 RCW, took
15 effect June 7, 2012. It provides that a person or entity is liable to the State for a civil penalty of
16 not less than five thousand five hundred dollars (\$5,500) and not more than eleven thousand
17 dollars (\$11,000), plus three times the amount of damages sustained because of the fraudulent
18 act of that person, if the person:

19 “[k]nowingly presents, or causes to be presented, a false or fraudulent
20 claim for payment or approval, [k]nowingly makes, uses, or causes to be
21 made or used, a false record or statement material to a false or fraudulent
claim, or [c]onspires to commit one or more of the [these] violations ...”

22 55. The Act defines certain key terms. In RCW 74.66.010(7)(a), “knowing” and
23 “knowingly” are defined to mean that a person, with respect to information, “[h]as actual
24 knowledge of the information; [a]cts in deliberate ignorance of the truth or falsity of the
25 information; or [a]cts in reckless disregard of the truth or falsity of the information.” RCW
26 74.66.010(7)(b) provides that “knowing” and “knowingly” do not require proof of specific

1 intent to defraud. RCW 74.66.010(8) provides that “material” means having a natural tendency
2 to influence, or be capable of influencing, the payment or receipt of money or property.

3 **VI. THE STATE’S CLAIMS AGAINST DEFENDANTS**

4 **FIRST CAUSE OF ACTION**

5 **(Violation of Medicaid Fraud False Claims Act – RCW 74.66.020(1)(a)-(b)
6 against all Defendants)**

7 56. Plaintiff State of Washington incorporates and re-alleges each allegation in
8 paragraphs 1 through 55 above as though fully set forth herein.

9 57. From January 1, 2011 through the present date, Defendants caused 138,730
10 claims for dental care services to be submitted to the Washington Medicaid program for
11 payment.

12 58. Defendants knew that they were only allowed to claim payment for dental care
13 services actually rendered to beneficiaries of the Medicaid program, that were covered for
14 payment purposes as explained in the HCA’s Provider Guides and regulations, and that were
15 properly billed in accordance with state and federal law, regulations, and the HCA’s billing
16 instructions.

17 59. At the time when Defendants submitted reimbursement claims on behalf of
18 CareOne to the State Medicaid program through the ProviderOne electronic billing system
19 (and on paper claim forms), Defendants knew that a substantial amount of the claims they
20 submitted for payment were not payable under HCA’s conditions of payment because the
21 claims included charges for services that were not covered, not performed, or undocumented,
22 or the billed service was more costly than the service actually delivered.

23 60. Each of the occasions when Defendants submitted an invoice requesting
24 payment for services that they knew to be non-covered, upcoded, undocumented, and/or
25 services that were never performed, constituted an instance of knowingly presenting for
26 payment either a false or fraudulent claim, or a false or fraudulent statement, under RCW
74.66.020. The total number of false claims presented will be proven at trial.

1 61. The HCA would not have paid any of the Defendants' claims that included
2 services that were not covered, not provided, not documented or billed incorrectly, had it
3 known that those claims included a fraudulent misrepresentation of the service actually
4 provided to the client.

5 62. Defendants' submission of false claims caused the Washington Medicaid
6 program managed by HCA to incur damages by paying for claims that violated the agency's
7 conditions of payment, in an amount to be proven at trial.

8 63. The mitigating factors of RCW 74.66.020(2) do not apply to Defendants in this
9 case.

10 64. Pursuant to RCW 74.66.020(1), Defendants are liable to the State for a civil
11 penalty of not less than five thousand five hundred dollars (\$5,500) and not more than eleven
12 thousand dollars (\$11,000) for each of the violations of RCW 74.66.020(1) identified above,
13 plus three times the amount of damages which the Medicaid program sustained as a result of
14 the false or fraudulent claims, or false records or statements material to false or fraudulent
15 claims, that Defendants caused to be presented following the effective date of the Washington
16 Medicaid Fraud False Claims Act. Defendants should be jointly and severally liable for the
17 damages, penalties, and interest.

18 **SECOND CAUSE OF ACTION**
19 **(Violation of Medicaid Provider Fraudulent Practices Statute [RCW 74.09.210]**
20 **Against all Defendants)**

21 65. The Plaintiff repeats and re-alleges each allegation in paragraphs 1 through 55
22 as though fully set forth herein.

23 66. Beginning in 2011 and continuing through the present date, Defendants
24 willfully made and/or caused to be made false statements, misrepresentations, or both, to the
25 State of Washington regarding the services they provided to Medicaid clients in their dental
26 practice. Defendants misrepresented the CDT codes applicable to services they performed on
their billings and claimed payment for services that were medically unnecessary. Defendants'

1 conduct was for the purpose of obtaining payments from the Washington Medicaid program.
2 Defendants' willful misrepresentations and false statements were the means by which they
3 obtained Medicaid payments that they were not legally entitled to receive. This conduct
4 violated RCW 74.09.210(1) (a) and (b).

5 67. Defendants fraudulently billed HCA for undocumented services, for noncovered
6 services such as preventive restorations, and for services that were not performed at all, and
7 therefore, Defendants violated RCW 74.09.210(1)(c) as well.

8 68. Defendants knew that (1) Medicaid only reimbursed providers for services
9 actually provided; (2) that they were required to accurately document their services and retain
10 such documentation for six years from the date of service; (3) they were to abide by the billing
11 instructions of the HCA and all applicable statutes and regulations; and (4) that they submitted
12 claims for payments that they were not legally entitled to receive. Moreover, Defendants knew
13 that they received Medicaid payments that they were not legally entitled to receive by means of
14 their willful false statements, misrepresentations, and fraudulent billing. Still, Defendants
15 submitted numerous monthly invoices to the State through the ProviderOne electronic billing
16 system (and on paper claim forms) including claims for Medicaid reimbursement representing
17 that they performed dental services that were in fact non-covered, upcoded, or undocumented
18 services, or were never performed.

19 69. Because Defendants knowingly violated RCW 74.09.210(1), pursuant to RCW
20 74.09.210(2), the State of Washington is entitled to: (1) repayment of the amount of excess
21 payments Defendants received, in an amount to be proven at trial, plus interest as specified in
22 RCW 43.20B.695; and (2) civil penalties not to exceed three times the amount of such excess
23 payments. Defendants should be jointly and severally liable for the damages, penalties, and
24 interest.

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THIRD CAUSE OF ACTION
(Common Law Fraud against all Defendants)

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3 70. Plaintiff State of Washington repeats and re-alleges each allegation in
4 paragraphs 1 through 55 above as though fully set forth herein.

5 71. Beginning in January 2011 and continuing through the present date, Defendants
6 knowingly made and/or caused to be made material false statements regarding the amount of
7 hours and the services they performed in the course of providing dental care for Washington
8 Medicaid clients. Defendants submitted numerous monthly invoices to the State through the
9 ProviderOne electronic billing system (and on paper claim forms) including claims for
10 Medicaid reimbursement representing that they performed dental services that were in fact
11 non-covered, upcoded, or undocumented services, or were never performed.

12 72. Defendants knew that the Washington Medicaid program relied on enrolled
13 providers to report their hours and services performed each month, and that the State paid only
14 for services actually performed, subject to the rules and limitations provided by statute,
15 regulation, and the HCA's Provider Guides. Thus, the Defendants' representations that they
16 had provided certain dental services which were in fact non-covered, upcoded, or
17 undocumented services, or were never performed, was material to the State of Washington's
18 decision to pay Defendants for the claimed services.

19 73. The Washington Medicaid program was not aware that Defendants'
20 misrepresentations were false. It rightfully and reasonably relied on Defendants'
21 representations about the services they provided and made payment accordingly to Defendants.
22 Defendants knew that their misrepresentations were material to the State's payment decision
23 and intended that their misrepresentations would induce the State to pay their claims.

24 74. Because it paid claims that it would not have paid but for Defendants'
25 misrepresentations, the State was injured and Defendants should be jointly and severally liable
26 for the resulting damages.

1 DATED this 10th day of September, 2015, at Olympia, Washington.

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