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

1.	UNITED STATES OF AMERICA *ex rel.* SANDRA SIMMONS;	
2.	THE STATE OF OKLAHOMA *ex rel.* SANDRA SIMMONS;	
3.	SANDRA SIMMONS, an individual,	
	Plaintiffs,	Case No. CIV-12-043-JHP
v.		**FILED *IN CAMERA* AND UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)**
1.	HEALTH MANAGEMENT ASSOCIATES, INC., a foreign corporation;	
2.	DURANT H.M.A., LLC, a domestic limited liability company d/b/a MEDICAL CENTER OF SOUTHEASTERN OKLAHOMA;	
3.	DURANT HMA PHYSICIAN MANAGEMENT, LLC, a domestic limited liability company; and	
4.	DAN J. CASTRO, M.D., an individual,	
	Defendants.	

THIRD AMENDED COMPLAINT

The plaintiff and relator, Sandra Simmons, on behalf of herself, the United States of America, and the State of Oklahoma, for her claims against the defendants, alleges and states as follows:

I.
INTRODUCTION

1. This is a *qui tam* action to recover treble damages and civil penalties on behalf of the United States of America under the False Claims Act, 31 U.S.C. § 3729 *et seq*. ("**FCA**"), and the State of Oklahoma under the Oklahoma Medicaid False Claims Act, OKLA. STAT. tit. 63, § 5053 *et*

seq., arising from false and fraudulent claims by Defendants presented to the United States and its governmental agencies and the State of Oklahoma and its agencies under federal and state Medicare and Medicaid programs.

2. These false and fraudulent claims were part of a scheme by Defendants whereby the United States and the State of Oklahoma were induced to pay for medical services that were not reimbursable under the federal health care programs.

3. Pursuant to the scheme, Defendants have defrauded, and conspired to defraud, the United States of America and the State of Oklahoma under the Medicare and Medicaid programs. These claims are based upon Defendants' false claims and false statements made in connection with the submission of their requests for payment to Medicare and Medicaid programs in order to obtain payment. These claims are also based on the unnecessary examinations, surgeries, and procedures conducted on patients that were subsequently improperly billed to Medicare and/or Medicaid, as well as on overcharging for services and charging for services that were not rendered.

4. This complaint has been originally filed *in camera* and under seal pursuant to 31 U.S.C. § 3730(b)(2) and OKLA. STAT. tit. 63, § 5053.2(B). It will not be served on Defendants until the Court so orders. A copy of the complaint and written disclosure of substantially all material evidence and information Plaintiff possesses have been served on the Attorney General of the United States, the United States Attorney for the Eastern District of Oklahoma, and the Attorney General for the State of Oklahoma contemporaneously herewith pursuant to 31 U.S.C. § 3730(b)(2), Fed. R. Civ. P. 4, OKLA. STAT. tit. 63, § 5053.2(B), and OKLA. STAT. tit. 12, § 2004(C)(1)(c)(5).

5. This is also a civil action that arises out of Defendants' wrongful discharge of Simmons' employment and is based on the following claims: (1) retaliation for engaging in protected

activity in violation of the False Claims Act, 31 U.S.C. § 3730(h); (2) retaliation for her internal and external reports of unlawful activities, for which Simmons was performing an important public obligation, exposing wrongdoing by Defendants and their staff, and performing an act that public policy would encourage, which was made actionable by the Oklahoma Supreme Court in *Burk v. K-Mart Corp*., 1989 OK 22, 770 P.2d 24; (3) retaliation for her use of medical leave in violation of the Family and Medical Leave Act ("**FMLA**"), 29 U.S.C. § 2601, *et. seq*.; (4) retaliation for placing Defendants on notice of a work related injury in violation of Oklahoma state law; and (5) retaliation in violation of OKLA. STAT. tit. 63, § 5053.5.

II.
JURISDICTION AND VENUE

6. This Court possesses subject matter jurisdiction over this action under 28 U.S.C. §§ 1331 and 1345, 31 U.S.C. §§ 3730 and 3732, and 29 U.S.C. § 2617(a)(2). The Court may exercise personal jurisdiction over the Defendants pursuant to 31 U.S.C. § 3732(a) because at least one of the Defendants resides or transacts business in this District and the claims described below occurred in this District. The Complaint has been filed timely within the period prescribed by 31 U.S.C. § 3731(b).

7. Furthermore, this Court has supplemental jurisdiction over Plaintiff's corresponding state law claims pursuant to 28 U.S.C. § 1367(a) because Plaintiff's state law claims arise out of the same core of operative facts as her federal claims.

8. Venue is proper in this District pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391(b) and (c) because at least one of the Defendants resides or transacts business in this District

and because Plaintiffs' claims arose in Bryan County, Oklahoma. Bryan County, Oklahoma, is located within this District.

III.
THE PARTIES

9. The United States of America brings this action by and through Sandra Simmons. At all times relevant to this Complaint, the United States funded the provision of medical care for eligible patients of Defendants pursuant to the federal Medicare and Medicaid programs, acting through the Centers for Medicare & Medicaid Services ("**CMS**"), which was formerly known as the Health Care Financing Administration, within the United States Department of Health and Human Services ("**HHS**"). Thus, the United States brings this action on behalf of its agencies, HHS and CMS, on behalf of the Medicare and Medicaid programs.

10. The State of Oklahoma brings this action by and through Sandra Simmons, as well. At all times relevant to this Complaint, the State of Oklahoma funded and/or managed the provision of medical care for eligible patients of Defendants pursuant to Medicare and Medicaid programs, acting via the SoonerCare program under the Oklahoma Health Care Authority.

11. Plaintiff and relator Sandra Simmons ("**Simmons**") is a citizen of the United States and a resident of Bryan County, Oklahoma. Simmons is a former employee of Defendants and brings this action on behalf of herself and the United States of America.

12. Simmons has direct and independent knowledge of the information on which the allegations in this Complaint are based. She voluntarily provided the information to the Government

before filing this suit. Both during her employment, in or around early 2010, and thereafter, on or about late 2011, Simmons notified the United States Attorney for the Eastern District of Oklahoma of the allegations now set forth in this Complaint.

13. The allegations and transactions set forth in this Complaint have not been publicly disclosed within the meaning of the False Claims Act or the Oklahoma Medicaid False Claims Act. Furthermore, Simmons is an original source of information given to the United States and the State of Oklahoma regarding Defendants' knowing engagement in illegal conduct in violation of federal and state laws and regulations that resulted in the payment of false or fraudulent claims by the United States and the State of Oklahoma in violation of the False Claims Act and the Oklahoma Medicaid False Claims Act.

14. In her capacity as the Area Director, Simmons acquired information that Defendants knew of the false or fraudulent claims presented to the United States and the State of Oklahoma for payment, deliberately concealed and failed to correct the conduct alleged below, and wrongfully retained the payments made to Defendants by the United States.

15. Defendant Health Management Associates, Inc. ("**HMA, Inc.**") is a foreign for-profit corporation that is the parent company of the other defendant entities named below that operate the Medical Center of Southeastern Oklahoma and its affiliated medical clinics that surround it (collectively, "**the Medical Center**") in Durant, Oklahoma. HMA, Inc. may be served with process by and through Patricia Dorris, Chief Executive Officer, 1800 W. University Boulevard, Durant, OK 74701.

16. Defendant Durant H.M.A., LLC ("**Durant HMA**") is a limited liability company organized under the laws of the State of Oklahoma and is a direct or indirect subsidiary of Defendant

HMA, Inc. Durant HMA is the corporate entity through which the Medical Center of Southeastern Oklahoma is operated. Durant HMA's registered agent for the service of process in Oklahoma is The Corporation Company, 1833 S. Morgan Rd., Oklahoma City, OK 73128.

17. Defendant Durant HMA Physician Management, LLC ("**Durant HMA Physician Management**") is a limited liability company organized under the laws of the State of Oklahoma and is a direct or indirect subsidiary of HMA, Inc. Durant HMA Physician Management's registered agent for the service of process in Oklahoma is The Corporation Company, 1833 S. Morgan Rd., Oklahoma City, OK 73128.

18. Upon information and belief, Durant HMA Physician Management is the corporate entity through which the employees at the Medical Center of Southeastern Oklahoma, including Plaintiff, are paid.

19. Defendant Dr. Dan J. Castro is an individual, board-certified physician in Otolaryngology who practiced in Durant, Oklahoma at the Medical Center of Southeastern Oklahoma from approximately 2005 to 2010.

20. Upon information and belief, HMA, Inc. directs, controls, and otherwise manages the business activities and operations of the Medical Center of Southeastern Oklahoma, its surrounding clinics, and its related corporate entities, including Durant HMA and Durant HMA Physician Management.

21. Defendants are located in the same physical place of business at the Medical Center, have common officers and/or directors, and share or co-determine matters governing the essential terms and conditions of employment for the employees working at the Medical Center. In addition, employees of Durant HMA Physician Management were required to utilize the human resources,

maintenance, information technology, food service, mail room, and other departments of HMA, Inc. and/or Durant HMA. Thus, these corporate entities are so closely related through operation and control that they engaged in a common enterprise and served as Plaintiff's joint employer at all times relevant to this case.

IV.
STATEMENT OF BACKGROUND FACTS

A. SANDRA SIMMONS WAS EMPLOYED AT THE MEDICAL CENTER OF SOUTHEASTERN OKLAHOMA AS AN AREA PHYSICIAN CLINIC MANAGER

22. Sandra Simmons began her employment with HMA on or about March 30, 2008, working at the Medical Center in the Durant Medical Complex until her wrongful termination on or about October 19, 2011.

23. Simmons was originally hired as an office manager for one of the clinics at the Medical Center. Within a few months, she assumed the responsibilities of payroll for the staff of Dr. Castro, who also operated a clinic at the Medical Center. Over the ensuing months, Simmons assumed additional responsibilities over Dr. Castro's clinic, including its daily operations, the management of its staff, its billing, and its referrals from SoonerCare.

24. As a result of her increased job responsibilities, Simmons was promoted to the Area Physician Clinic Manager ("**Area Manager**") in or around May or June of 2009.

25. As an Area Manager, Simmons supervised three (3) site managers of the Medical Center who managed the offices of approximately nine (9) physicians. As an Area Manager, Simmons was responsible for a variety of tasks, including, but not limited to, implementing and

ensuring compliance with policies and procedures. This responsibility included implementing and ensuring compliance with the policies and procedures regarding Dr. Castro's billing, which included billing to Medicare, Medicaid, and SoonerCare.

B. DR. CASTRO'S EMPLOYMENT WITH THE MEDICAL CENTER OF SOUTHEASTERN OKLAHOMA

26. Defendants operate the Medical Center of Southeastern Oklahoma and the affiliated medical clinics that surround it in Durant, Oklahoma. Among other things, the Medical Center operates a 148 bed Acute Care Hospital and the surrounding clinics, with a medical staff of over 100 physicians that serve the public in southeastern Oklahoma.

27. Dr. Castro began working for Defendants in 2005 as an otolaryngologists who performed both surgical and non-surgical treatment of Defendants' patients involving the ear, head, and neck. Dr. Castro also performed medical services as a dermatologist.

28. Dr. Castro had a clinic on-site at the Medical Center Complex but always remained an HMA employee. The clinic was staffed by approximately three to four (3 to 4) individuals at any given time, including Dr. Castro, a registered nurse, and office personnel.

29. Initially, Simmons learned that Dr. Castro operated under the Medical Center's tax identification number. In or around 2009, Simmons learned that Dr. Castro began operating under Durant Physician Management's tax identification number. At no time, to the best of Simmons' knowledge and belief, did Dr. Castro have a separate tax identification number or business entity of his own. Rather, Dr. Castro worked under Defendants' corporate entities.

30. From approximately 2005 to 2010, Dr. Castro operated at the Medical Center with a contract through the Oklahoma Health Care Authority. In or around 2009, however, Dr. Castro's Medicaid contract was cancelled due to his fraudulent and unlawful activities.

31. During his employment with the Medical Center, Dr. Castro had a contract with the Defendants that provided that he was entitled to collect his monthly billing and work at the Medical Center and clinic in exchange for paying a monthly administrative fee to the other Defendants. This administrative fee was based on the percentage of billing Dr. Castro collected each monthly. Thus, the more Dr. Castro billed, the more monetary gain Defendants received.

C. THE FEDERAL HEALTH CARE PROGRAMS OF MEDICARE AND MEDICAID

32. In 1965 Congress enacted, and President Lyndon B. Johnson signed, the Social Security Amendments of 1965, which added Title XVIII and Title XIX to the Social Security Act, 42 U.S.C. § 1395 *et seq*. These two amendments created, respectively, the federal Medicare and Medicaid programs. Medicare authorizes medical benefits and health financing to the aged and disabled, while Medicaid authorizes medical benefits and health financing to persons and families with low income and certain disabilities.

33. At the federal level, the Department of Health and Human Services ("**HHS**") is responsible for the administration and supervision of the Medicare and Medicaid programs. The Centers for Medicare and Medicaid Services ("**CMS**") is an agency of HHS and is directly responsible for the administration and supervision of the Medicare and Medicaid programs.

34. Both Medicare and Medicaid are federal programs. Medicare is exclusively funded and administered by the United States government, while Medicaid is jointly funded and administered by both the state and federal governments.

35. In 1993, the State of Oklahoma enacted OKLA. STAT. tit. 63, § 5004, *et seq*., for purposes of created the Oklahoma Health Care Authority ("**OHCA**") to manage the Medicaid program at the state level.

36. Oklahoma currently manages the Medicaid program through a managed care plan known as SoonerCare. SoonerCare is administered through OHCA, which is responsible for purchasing health insurance benefits for Oklahoma's SoonerCare members. A primary beneficiary of the SoonerCare program are children in low-income families. In fact, Oklahoma's Medicaid Program covers children up to the age of 21 whose family's income is a certain percentage of the federal poverty level. OHCA also enrols eligible children in the State Children's Health Insurance Program ("**S-CHIP**").

37. Under the federal Medicare program's Part B, payment to practitioners for medical services is only authorized for doctor's services and outpatient care that are medically necessary. *See* 42 U.S.C. § 1320c-5.

38. Furthermore, under Part B, Medicare will pay for services "incident to the services of a physician" so long as the services are provided under the "direct supervision" of the physician. 42 C.F.R. § 410.26(b)(5). However, since 2002, "direct supervision" has required that the physician "be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure." 42 C.F.R. § 410.26(a)(2), 410.32(b)(3)(ii). Thus, in order to lawfully seek reimbursement for services under Medicare, a physician must be present in the office when the services were rendered.

39. Similarly, the Medicaid Program, as administered by the state of Oklahoma, authorizes payment to practitioners for only those services that are "medically necessary and

essential to the diagnosis and treatment of the patient's presenting problem." Oklahoma Administrative Code § 317:30-3-1(d).

D. DEFENDANTS' PROCEDURE FOR BILLING MEDICARE AND MEDICAID

40. Defendants derive a substantial portion of their revenue from the Medicare and Medicaid programs.

41. For example, from 2009 to 2010, there were approximately 45 million Americans that were provided health insurance through Medicare, nearly 600,000 of whom lived in Oklahoma.

42. Likewise, according to the OHCA, as of April 2012 there were approximately 764,715 persons enrolled in SoonerCare in Oklahoma, approximately 65% of whom were children. In Bryan County alone, which has an estimated population of 42,416, there were 10,778 persons enrolled in SoonerCare that month. In total, approximately 30.47 % of Bryan County's population was covered by Medicaid in some form in Oklahoma's 2011 fiscal year, with a total expenditure in Bryan County alone of $48,019,060.

43. Under the Hospital Outpatient Prospective Payment System ("**PPS**"), which CMS has utilized since approximately 2000, in most cases hospitals are paid on the basis of fixed rates based on the Ambulatory Payment Classification ("**APC**") for the service provided.

44. In addition, CMS and OHCA, in administering SoonerCare, pay physicians on the basis of a pre-determined Physician Fee Schedule.

45. In order to determine the lawful amount of payment, CMS utilizes a coding system called Current Procedural Terminology or "CPT codes." Utilizing CPT codes is a common method

for coding physician services and procedures for purposes of seeking reimbursement from the Medicare and Medicaid programs. Physicians submit claims for reimbursement using forms, which are completed by using the appropriate CPT code to describe the services rendered and billed.

46. Under the federal and state health care programs, it is illegal to code or bill for services not actually rendered, to provide medically unnecessary services, to code for more services than actually rendered, or otherwise fail to follow established billing and coding guidelines.

47. Seeking payment for medically unnecessary services is an act designed to obtain reimbursement for a service that is not warranted by the patient's current and documented medical condition. *See, e.g.,* 42 U.S.C. § 1395y(a)(1)(A) ("no payment may be made under part A or part B for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of the malformed body member").

48. CMS and OHCA make payments to hospitals and practitioners for inpatient and outpatient services. Reimbursement claims by beneficiaries of the programs are filed either directly by the beneficiary or their health care providers. The claims then are paid by carriers and intermediaries pursuant to contracts. The carrier or intermediary is reimbursed for claims paid out of federal trust funds.

49. In order to process payments for patients at the Medical Center, Dr. Castro and Defendants utilized "fee tickets" that listed the CPT code for the services provided. Dr. Castro also dictated his course of treatment for each patient, which was eventually transcribed and placed in the patient's paper chart by his office staff.

50. Dr. Castro's office staff also utilized software provided by both Regional Medical Resources (**"RMR**") and NextGen Healthcare ("**NextGen**") to bill and code the medical services provided.

51. Once a patient's medical services were coded into the NextGen program, Dr. Castro's billing was performed by a third party administrator called Gateway EDI, an electronic date interchange company, that was responsible for, among other things, processing the claims for reimbursement from Medicare and Medicaid. Once the charges were entered into NextGen, they would then be sent electronically to the payers by utilizing Gateway. Defendants paid another third party company, Practice Solutions, to make sure the claims were sent each night to Gateway. Claims would go to Gateway, and Gateway would check for errors. If the claim passed, Gateway sent the claims to the payor and then for processing. If the claims failed, the claims would be sent back to Defendants as a rejected claim by Gateway with a code that explained reason.

52. Pursuant to the federal and state health care program requirements, all documentation supporting claims or request for payment must be complete, accurate, and reflect reasonable and necessary services ordered by an appropriately licensed medical professional who is a participating provider in the health care program from which reimbursement is sought.

53. Defendants have presented claims for payment to the United States and the State of Oklahoma for specific services provided to individual beneficiaries and claims for general and administrative costs incurred in treating Medicare and Medicaid beneficiaries in violation of federal and state law.

E. THE FALSE CLAIMS ACT

54. The False Claims Act, 31 U.S.C. §§ 3729 *et seq*. ("**FCA**") provides in pertinent part, that any person who

> (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
>
> (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
>
> (C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-4101), plus 3 times the amount of damages which the Government sustains because of the act of that person.

31 U.S.C. § 3729(a)(1).

Moreover, The FCA defines the terms "knowing" and "knowingly" to mean:

> (A) that a person, with respect to information–
>
> (I) has actual knowledge of the information;
>
> (ii) acts in deliberate ignorance of the truth or falsity of the information; or
>
> (iii) acts in reckless disregard of the truth or falsity of the information; and
>
> (B) require no proof of specific intent to defraud;

31 U.S.C. § 3729(b)(1).

E. THE OKLAHOMA MEDICAID FALSE CLAIMS ACT

55. Similarly, the Oklahoma Medicaid False Claims Act provides the following:

> B. Any person who:

> 1. Knowingly presents, or causes to be presented, to an officer or employee of the State of Oklahoma, a false or fraudulent claim for payment or approval;
>
> 2. Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state;
>
> 3. Conspires to defraud the state by getting a false or fraudulent claim allowed or paid;
>
> 4. Has possession, custody, or control of property or money used, or to be used, by the state and, intending to defraud the state or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;
>
> 5. Is authorized to make or deliver a document certifying receipt of property used, or to be used, by the state and, intending to defraud the state, makes or delivers the receipt without completely knowing that the information on the receipt is true;
>
> 6. Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state, who lawfully may not sell or pledge the property; or
>
> 7. Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state,
>
> is liable to the State of Oklahoma for a civil penalty of not less than Five Thousand Dollars ($5,000.00) and not more than Ten Thousand Dollars ($10,000.00), unless a penalty is imposed for the act of that person in violation of this subsection under the federal False Claims Act for the same or a prior action, plus three times the amount of damages which the state sustains because of the act of that person.

OKLA. STAT. tit. 63, § 5053.1.

V.
DEFENDANTS' UNLAWFUL SCHEME TO DEFRAUD MEDICARE AND MEDICAID

56. Upon Simmons' best information and belief, approximately seventy percent (70%) of Dr. Castro's patients were on Medicaid and/or SoonerCare, with a smaller percentage on

Medicare. Furthermore, at its highest level, Dr. Castro collected approximately $750,000 on a monthly basis for his services. As set forth above, Defendants benefitted financially from Dr. Castro's billing in the form of an administrative fee based on a percentage of his monthly collections.

57. During the course of her employment, Simmons discovered that Dr. Castro, in conspiracy with the other Defendants, was engaged in an unlawful scheme to defraud Medicare and Medicaid as set forth below. Simmons exposed this fraudulent activity to Dr. Castro and Defendants on multiple occasions.

A. DR. CASTRO PERFORMED EXCESSIVE & MEDICALLY UNNECESSARY SURGERIES

58. During the course of her employment, Simmons discovered that Dr. Castro was performing medically unnecessary surgeries for which he sought reimbursement from Medicare and Medicaid in violation of federal law.

59. Simmons ran a report on the number of surgeries Dr. Castro was performing and discovered, for example, that an astonishing number, approximately 70%, of Dr. Castro's new patients were scheduled for surgical procedures.

60. For example, Dr. Castro performed numerous sinus surgeries that were not medically necessary on both children and adults. Among other surgeries, Dr. Castro often performed Endoscopic Anterior and Posterior Ethmoidectomies, Endoscopic Middle Meatal Antrostomies, Endoscopic Sphenoid Sinusotomies, Resections of Concha Bullosa, and Septoplasties.

61. Significantly, endoscopic sinus surgeries should not routinely be performed on pediatric patients.

62. Dr. Castro also performed surgical procedures for the removal of skin lesions at the Hospital that could have been performed at the clinic.

63. In addition, Dr. Castro placed permanent tubes in ears of patients that required surgical removal. However, had Dr. Castro placed temporary tubes when he could have, then surgery would not have been needed for removal but instead the temporary tubes would have dissolved on their own.

64. In addition, Dr. Castro schedule surgeries before the results of the patient's computed tomograph ("**CT**") scan had even been received by his clinic.

65. Furthermore, Dr. Castro performed numerous debridements during post-operation procedures that were not medically necessary and/or otherwise not reimbursable under the federal health care programs.

66. Significantly, all Defendants benefitted financially from Dr. Castro's excessive and medically unnecessary surgeries. Dr. Castro, of course, benefitted directed by billing patients for surgeries that were not medically necessary. Defendants also benefitted by filling for hospital administration fees, facility fees, surgical charges, medications, and others services.

67. Dr. Castro's excessive surgical procedures resulted in him performing the surgery when he knew it was not medically necessary in order to unlawfully increase his monthly billing collections.

68. Thus, Dr. Castro, in conspiracy with Defendants, submitted false and fraudulent claims to Medicare and/or Medicaid for reimbursement for surgeries that were medically unnecessary in violation of federal law.

B. DR. CASTRO ROUTINELY PERFORMED MEDICALLY UNNECESSARY NASOPHARYNGOSCOPIES

69. Furthermore, during the course of her employment, Simmons discovered that Dr. Castro was routinely performing a procedure called a "nasopharyngoscopy" on all new patients regardless of whether it was essential to the diagnosis and treatment of the patient's presenting problem or not.

70. A nasopharyngosopy is a medical procedure that permits a doctor to examine the internal surfaces of the nose and throat, which is called the nasopharynx. To perform the procedure, Dr. Castro used a flexible fiberoptic scope (called a nasopharyngoscope) that takes the shape of a thin tube and that utilizes lenses and light to reveal the surfaces of the nose and throat. A local anesthetic and/or sedative is sometimes used.

71. While a nasopharyngoscopy can often be a useful tool in diagnosing and examining patients complaining of ear, nose, and throat symptoms, Dr. Castro was performing the procedure on each and every single new patient that visited his clinic regardless of their symptoms.

72. In fact, every new patient was required to fill out an authorization that permitted Dr. Castro to perform the procedure as part of the new patient packet that was given to the patient before Dr. Castro had even seen them.

73. Even more troubling, Dr. Castro also performed the nasopharyngoscopy on all new *dermatology* patients who were presenting with skin rashes, lesions, and other problems that did not require examination of the surface of the nose and throat.

74. Thus, Dr. Castro's excessive use of the nasopharyngoscopy procedure resulted in him performing the procedure when he knew it was not medically necessary.

75. Defendants benefitted directly by Dr. Castro's increased monthly collections that were received as a result of his medically unnecessary nasopharyngoscopies.

76. Dr. Castro, in conspiracy with Defendants, submitted false and fraudulent claims to Medicare and/or Medicaid for reimbursement for nasopharyngoscopies that were medically unnecessary in violation of federal law.

77. Furthermore, Dr. Castro routinely and unlawfully billed Medicare and Medicaid for nasopharyngoscopies that he performed as part of his standard of care and thus should not have been reimbursed separately.

C. DR. CASTRO ROUTINELY OVER-CODED NEW PATIENT VISITS

77. Simmons also discovered that Dr. Castro improperly "up-coded" his patient visits on a regular and routine basis.

78. Up-coding involves the use of a billing code that provides a higher rate of payment than a code that actually reflects the patient's condition or the service furnished to the patient.

79. With all patients, Dr. Castro filled out a fee ticket that listed the services rendered and provided a CPT code for each visit. Each fee ticket listed the level of service rendered, one through five. A one (1) indicates the lowest level of services rendered, while a five (5) indicates the highest level of services rendered.

80. To determine which level of service to mark for each patient, Dr. Castro was required to evaluate several factors, including the medical decisions he made during the visit, the patient's history, and the patient's complaining symptoms. These factors are complex and require an individual determination based on the examination provided.

81. A level one (1) for example, which for a new patient is CPT code 99201 and for an established patient is CPT code 99211, should be marked when there is a low level of complexity for the complaint, history of illness, and review of symptoms.

82. A level three (3), for example, which for a new patient is CPT code 99203 and for an established patient is CPT code 99213, should be marked when there is a medium level of complexity for the complaint, history of illness, and review of symptoms.

83. A level five (5), for example, which for a new patient is CPT code 99205 and for an established patient is CPT code 99215, should be marked when there is a high level of complexity for the complaint, history of illness, and review of symptoms.

84. For each level, there is a Relative Value Unit ("**RVU**") assigned. Thus, for the higher levels, Dr. Castro was reimbursed more from Medicare and Medicaid, and for the lower levels, he was reimbursed less.

85. Dr. Castro, however, did not distinguish between his patients on the level of services rendered. Instead, he marked nearly every visit a three (3). Upon discovering this, Simmons ran a Coding Frequency Report for new and established patients. Shockingly, Simmons discovered that Dr. Castro marked a level three (3) for approximately ninety-nine percent (99%) of patient visits.

86. Dr. Castro knew that each patient was not a level three (3), but that he was required to differentiate between levels of services provided.

87. Thus, Dr. Castro, in conspiracy with Defendants, submitted false and fraudulent claims to Medicare and/or Medicaid for reimbursement for heightened coding of examinations for higher reimbursement for services in violation of federal law.

D. DR. CASTRO SOUGHT REIMBURSEMENT FOR SERVICES THAT WERE PERFORMED WHILE DR. CASTRO WAS NOT IN THE CLINIC

88. In addition, Simmons discovered that Dr. Castro was seeking reimbursement from Medicaid and Medicare when Dr. Castro was not in the clinic. However, as set forth above, federal law require a physician to be present in the office when the services were rendered in order to qualify for reimbursement.

89. For example, Simmons discovered that Dr. Castro billed for allergy testing, mixing, an injections that were performed while he was not in the clinic. Rather, Dr. Castro's schedule typically followed the following pattern: (a) On Monday, Dr. Castro performed surgery at the hospital for half a day and worked in his clinic for the remainder of the day; (b) On Tuesday and Friday, Dr. Castro performed surgery at the hospital all day; and (c) on Wednesday and Thursday, Dr. Castro worked in his clinic all day.

90. Simmons discovered that Dr. Castro was submitting bills for services that were not rendered while he was in the clinic but instead were rendered while he was at the hospital performing surgery.

91. Dr. Castro knew that he was not in the clinic on the dates these services were rendered.

92. Defendants benefitted directly by Dr. Castro's increased monthly collections that were received as a result of his unlawful billing.

93. Thus, Dr. Castro, in conspiracy with Defendants, submitted false and fraudulent claims to Medicare and/or Medicaid for reimbursement for services rendered when he was not supervising in violation of federal law.

E. DEFENDANTS WERE ENGAGED IN A CONSPIRACY TO DEFRAUD THE UNITED STATES AND THE STATE OF OKLAHOMA

94. Because of their interrelated financial relationship, Defendants entered into an agreement whereby they would acquiesce, consent to, condone, and otherwise approve Dr. Castro's fraudulent billing activities.

95. Thus, Defendants employed Dr. Castro with the knowledge and intend to defraud the state and federal health care programs. Defendants continued to employ Dr. Castro so long as his fraudulent billing activities financially benefitted them, after they were aware of his fraudulent billing activities.

96. Defendants acted in conspiracy to defraud the state and federal health care programs. Dr. Castro was an employee and/or agent of Defendants during his tenure as a physician at the Medical Center of Southeastern Oklahoma.

VI.
SIMMONS' INDIVIDUAL RETALIATION CLAIMS

97. In her position as Area Manager, Simmons reported to Jamie McGaugh ("**McGaugh**"), Assistant Controller of the Medical Center, from approximately November 2008 until her wrongful termination.

98. As set forth in more detail above, upon assuming her new role as Area Manager, Simmons began to notice and express her concerns for the unlawful, irregular, fraudulent, and otherwise unethical activities in which Dr. Castro was engaged.

99. In addition to those issues detailed above, Simmons discovered that billing and other paperwork in Dr. Castro's clinic were apparently being falsified because Medicare and SoonerCare patients were supposedly receiving medical services while Dr. Castro was not present in his clinic. Furthermore, Simmons discovered that the proper referrals from the primary care physicians were not being obtained for these same patients, and thus that Dr. Castro was not obtaining or submitting the proper documentation for his medical services.

100. Perhaps more shockingly, Simmons discovered that the percentage of Dr. Castro's new patients that were recommended for surgery by Dr. Castro was extremely high. Simmons also noticed that Dr. Castro was performing surgeries in the hospital that could have been performed within the clinic, and that Dr. Castro was pressuring his staff to talk potential surgery candidates into potentially medically unnecessary surgeries. Furthermore, several patients complained to the billing office that their surgical fees were excessive.

101. In or around the fall of 2009, the United States Attorney for the Eastern District of Oklahoma raided Dr. Castro's clinic to collect medical records and billing records in order to audit around approximately three-hundred (300) original patient's medical records. As part of this audit, the U.S. Attorney requested several hundred thousand dollars back from Dr. Castro because of his irregular and fraudulent billing practices.

102. Simmons was required to review each chart in question as part of this audit so that the necessary paperwork for an appeal could be completed. In addition, Simmons was questioned by an investigator with the U.S. Attorney's office about her knowledge of Dr. Castro's irregular and fraudulent billing practices and surgeries.

103. Furthermore, in 2010, Simmons was questioned by a panel about Dr. Castro's irregular and fraudulent billing practices and surgeries. During her questioning, Simmons confirmed that Dr. Castro was engaged in irregular and fraudulent billing practices, explained her concern about the high percentage of patients who were scheduled for surgery, told the panel of Dr. Castros' odd behavior towards patients who cancelled surgeries and the pressure he exerted on his staff to talk patients into surgery, and confirmed that Dr. Castro was performing medically unnecessary surgeries on patients.

104. Simmons attempted to correct the irregular and fraudulent billing practices and instructed the staff of Dr. Castro's clinic of the proper manner in which to perform various functions. However, Dr. Castro often disagreed with Simmons' directives and went to officials above Simmons in the chain of command, including the Medical Center's Chief Financial Officer and/or the Chief Executive Officer, in an effort to circumvent and disregard her corrective instructions.

105. Simmons repeatedly complained about Dr. Castro's irregular and fraudulent billing practices to McGaugh, her direct supervisor. In fact, Simmons complained to McGaugh on nearly a weekly basis.

106. In 2010, Simmons became pregnant and informed McGaugh of her pregnancy.

107. After McGaugh became aware that Simmons was planning on taking FMLA-qualifying leave for her pregnancy, McGaugh repeatedly questioned Simmons about the length of time she planned to take off work for maternity leave. During these conversations, McGaugh appeared to be unhappy with the fact that Simmons was likely going to take the full 12 weeks of medical leave to which she was entitled under the FMLA.

108. This was not Simmons' first time to experience McGaugh's displeasure at an employee taking FMLA leave. In fact, in or around November 2010, an employee under Simmons' supervision, who was a nurse in one of the Medical Center's clinics, took maternity leave for the full twelve weeks allowed under the FMLA. During that time, McGaugh repeatedly expressed her unhappiness with the fact that the employee had used the full 12 weeks of FMLA leave for maternity leave.

109. On or about April 8, 2011, Simmons requested and was approved for medical leave under the FMLA in order to give birth to her child. Specifically, Simmons requested medical leave from the Human Resources Manager of the Medical Center, Erin Mosley, whose office was in the Medical Center's hospital.

110. Thus, Simmons took maternity leave under the FMLA from approximately April to July 2011.

111. Significantly, while on maternity leave, Simmons was subpoenaed by the government in or around May 2011 to testify before a grand jury regarding Dr. Castro's irregular and fraudulent billing and surgeries.

112. After she was subpoenaed and while she was on maternity leave, Simmons was required to discuss the subpoena and her potential testimony at the Medical Center with both McGaugh and counsel for HMA. During these conversations, Simmons again exposed Dr. Castro's irregular and fraudulent billing and surgeries and explained her involvement in uncovering these practices and her efforts to correct them.

113. Simmons returned to work on or around July 5, 2011.

114. Upon her return to work, HMA began to retaliate against Simmons because of her use of medical leave and because of her involvement in exposing Dr. Castro's wrongdoing.

115. Specifically, upon her return to work, Simmons was treated differently by her direct supervisor, McGaugh, and by McGaugh's supervisor, Chief Financial Officer Phil Baker ("**Baker**"). HMA's retaliatory treatment of Simmons continued over the course of the ensuing three (3) months and culminated in her wrongful discharge.

116. For example, immediately following her return to work, Simmons was excluded by McGaugh and/or Baker from meetings that involved her established responsibilities as Area Manager. In addition, her decision-making authority over matters involving her established responsibilities as Area Manager were taken away by McGaugh and/or Baker. On other occasions, McGaugh assigned Simmons new work assignments that were difficult to complete in an effort to force Simmons to fail.

117. Before her return to work in July 2011, Simmons was responsible as Area Manager for managing the transition to the Medical Center for new physicians who signed a contract to provide medical services for the Medical Center. Baker, McGaugh, Simmons, the physician, and the relevant department heads would attend meetings to discuss the physician's various needs. Simmons was also responsible for managing the transition for physicians who were departing from the Medical Center, including providing for the distribution and placement of office space, furniture. In fact, Simmons was responsible for coordinating the hiring of clinic staff and establishing the staff's pay.

118. Beginning in July 2011, however, Defendants excluded Simmons from these responsibilities, meetings, and decisions. Rather, Baker and/or McGaugh conducted the transition

meetings without Simmons, precluded Simmons from performing her personnel responsibilities, and assigned Simmons' responsibilities to other employees who upon Plaintiff's best information and belief had not taken FMLA leave nor complained about Dr. Castro's unlawful activity.

119. Furthermore, Simmons was repeatedly left out of the loop by McGaugh and/or Baker regarding information she needed to properly perform the full scope of her job duties.

120. Simmons complained to McGaugh about Defendants' retaliatory treatment on approximately two occasions. Specifically, Simmons complained that HMA was preventing her from properly performing her job duties and was not providing her the necessary information she needed to do her job properly. Despite her complaints, however, HMA's retaliatory treatment continued.

121. Defendants' conduct toward Simmons was done in an effort to force Simmons out of her employment and/or to otherwise retaliate against her.

122. While Defendants' retaliatory conduct continued, on or about August 1, 2011 Simmons discovered an alarming odor coming from within one of the Medical Center's clinics and requested a mold test be obtained. The initial mold test came back positive.

123. As a result of this mold, Simmons became congested, wheezy and developed a cough. Simmons often had acute attacks of congestion, wheezing, and coughing while she was at work that lasted for a prolonged period of time. These symptoms persisted until her wrongful termination but ceased after her employment ended.

124. Simmons met with Baker and McGaugh (along with the Medical Center's Chief Operating Officer, Maintenance Director, Materials Management Director, and Information Technology supervisor) to discuss her complaint about the mold in the clinic and her medical

condition. Specifically, during this meeting, Simmons described her congestion, wheeze, and cough, explained her fear that her medical condition was worsening because of the presence of the mold, and requested that HMA identify the type of mold that was present.

125. In fact, Simmons repeatedly requested that HMA identify the type of mold present in the Medical Center's clinic so that she could take the appropriate steps to cure her work related injuries. HMA, however, never responded to Simmons' requests.

126. On or about September 26, 2011, Simmons' husband complained to the Occupational Safety and Health Administration ("**OSHA**") of the mold issues within the clinic on Simmons' behalf.

127. The following day, HMA's Risk Management Director approached Simmons about her mold complaint. Simmons again expressed her concerns over the mold and its impact on the health and safety of those in the clinic. Simmons also explained her worsening medical condition.

128. On or about October 4, 2011, Simmons requested of the Risk Management Director, Patsy Naifeh, a medical review for herself and the other employees of the clinic.

129. On or about October 7, 2011, Simmons had a medical review of her medical symptoms conducted at the Medical Center. Simmons was given a prescription for an inhaler at the medical review. Simmons was also directed to avoid exposure to the mold in the clinic.

130. Following her medical review, Simmons contacted HMA's human resources department on at least three (3) separate occasions to inform HMA of her need for HMA's workers compensation insurance to pay to have her prescription inhaler filled. Simmons specifically expressed her desire for workers compensation coverage. HMA's human resources department

informed Simmons that she needed an authorization number for workers compensation to cover her prescription. Despite Simmons' repeated requests for this authorization number, however, HMA never provided it to her.

131. On or about October 19, 2011, Simmons was notified by OSHA that it was closing the file on her mold complaint.

132. On or about October 19, 2011, Simmons was wrongfully discharged from her employment with HMA in a meeting with Baker, the CFO, and Patricia Dorris, the Chief Executive Officer of the Medical Center. Notably, Baker was the direct supervisor of McGaugh.

133. During her termination meeting, Simmons was told by Baker that HMA "was going to make a change" and that she was fired. Simmons was then presented with a write-up that falsely claimed, among other things, that Simmons violated company policy by giving preferential treatment to the staff for their use of sick time and for failing to wear her name badge.

134. The stated reasons for Simmons' discharge, however, were merely pretext for the underlying retaliation.

135. Simmons did not give employees preferential treatment in their use of sick time. Thus, this stated justification for HMA's discharge of Simmons was false.

136. Furthermore, Simmons had never been disciplined or counseled over her alleged failure to wear her name badge. And, HMA did not uniformly enforce discipline in regards to its name badge policy upon Simmons' best information and belief. Thus, HMA's decision to discharge Simmons because of an alleged failure to wear a name badge was subjective and not in accordance with HMA's standard disciplinary procedure.

137. After Simmons was terminated, McGaugh told at least two fellow employees that Simmons was no longer "hands off" because HMA had compiled enough pretextual "information" on Simmons to support its wrongful termination.

138. HMA wrongfully discharged Simmons in violation of the FMLA by retaliating against her for her use of medical leave. Furthermore, HMA wrongfully discharged Simmons in violation of Oklahoma state law by retaliating against her for exposing Dr. Castro's wrongdoing, for making a complaint of mold at the Medical Center (a public place where health and safety is paramount), and for placing HMA on notice of her work related injury.

139. As a direct and proximate result of HMA's unlawful conduct, Simmons has suffered injuries and incurred damages.

VII.
THEORIES OF RECOVERY

A. FIRST CLAIM
FALSE CLAIMS ACT: PRESENTATION OF FALSE CLAIMS

For her first cause of action, Plaintiff incorporates all of her prior allegations and further alleges and states as follows:

140. This is a claim for treble damages and forfeitures under the False Claims Act, 31 U.S.C. § 3729(a)(1)(A).

141. Defendants knowingly presented or caused to be presented false or fraudulent claims for payment or approval of medical services to the United States.

142. Unaware of the falsity of Defendants' claims, and in reliance on the accuracy thereof, the United States paid Defendants for claims that would otherwise not have been allowed.

143. Each false or fraudulent claim paid by the United States is a separate violation of the False Claims Act.

144. By virtue of these payments, the United States has been damaged, and continues to be damaged, in a substantial amount. The United States therefore is entitled to multiple damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000.00 to $10,000.00 for each violation.

B. SECOND CLAIM
FALSE CLAIMS ACT: MAKING OR USING FALSE RECORD OR STATEMENT TO CAUSE FALSE CLAIM TO BE PAID

For her second cause of action, Plaintiff incorporates all of her prior allegations and further alleges and states as follows:

145. This is a claim for treble damages and forfeitures under the False Claims Act, 31 U.S.C. § 3729(a)(1)(B).

146. Defendants knowingly made, used, or caused to be made or used, false records or statements to get false or fraudulent claims paid or approved by the United States. These false records or statements include, but are not limited to, false certifications and representations made or caused to be made by Defendants to the federal or state authorities in conjunction with the scheme to present false or fraudulent claims for payment or approval of medical services.

147. Unaware of the falsity of Defendants' records or statements, and in reliance on the accuracy thereof, the United States paid Defendants for claims that would otherwise not have been allowed.

148. Each false record or statement is a separate violation of the False Claims Act.

149. By virtue of these false records or false statements made by Defendants, the United States has been damaged, and continues to be damaged, in a substantial amount. The United States therefore is entitled to multiple damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000.00 to $10,000.00 for each violation.

C. THIRD CLAIM
FALSE CLAIMS ACT: CONSPIRING TO SUBMIT FALSE CLAIMS

For her third cause of action, Plaintiff incorporates all of her prior allegations and further alleges and states as follows:

150. This is a claim for treble damages and forfeitures under the False Claims Act, 31 U.S.C. § 3729(a)(1)(C).

151. Defendants entered into agreements and conspired to defraud the United States by submitting false or fraudulent claims for reimbursement from the United States for monies to which they were not entitled. As part of the schemes and agreements to obtain reimbursement from the United States in violation of federal laws, Defendants conspired to cause the United States to pay claims for health care services based on false claims and false statements that the services were provided in compliance with all laws regarding the provision of health care services when, in fact, the services violated the law.

152. By virtue of Defendants' conspiracy, the United States has been damaged, and continues to be damaged, in a substantial amount. The United States therefore is entitled to multiple damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000.00 to $10,000.00 for each violation.

D. FOURTH CLAIM
FALSE CLAIMS ACT: WRONGFUL DISCHARGE

For her fourth cause of action, Plaintiff incorporates all of her prior allegations and further alleges and states as follows:

153. This is a claim for retaliation in the form of wrongful discharge under the False Claims Act, 31 U.S.C. § 3730(h).

154. Defendants wrongfully discharged Plaintiff for exposing and complaining about their fraudulent billing to the federal health care programs. In speaking out about Defendants' unlawful activity, Plaintiff was engaged in protected activity under the False Claims Act.

155. As a result of Defendants' unlawful conduct, Plaintiff has been damaged. She is entitled to all damages permitted by the False Claims Act, including but not limited to lost wages, two (2) times the amount of back pay, interest on the back pay, compensation for any special damages sustained as a result of the discrimination, and attorney fees and costs.

E. FIFTH CLAIM
***BURK* TORT**

For her fifth cause of action, Plaintiff incorporates all of her prior allegations and further alleges and states as follows:

156. The matters alleged above constitute a violation of Oklahoma's public policy which prohibits wrongful termination and retaliation against a whistle-blower for performing an act consistent with a clear and compelling public policy, *i.e.*, refusing to participate in an illegal activity; performing an important public obligation; exercising a legal right or interest; exposing some wrongdoing by the employer; and performing an act that public policy would encourage or for

refusing to do something that public policy would condemn. Specifically, Plaintiff's reports concerning Dr. Castro's irregular and fraudulent billing practices and surgeries, and her report of the hazardous mold growth within the Medical Center, protected Plaintiff from retaliation or wrongful termination.

157. As damages, Plaintiff has suffered lost earnings, past and future, and other compensatory damages.

158. Because the actions of Defendants were willful, wanton or, at the least, in reckless disregard of Plaintiff's rights, Plaintiff is entitled to punitive damages.

F. SIXTH CLAIM
FMLA RETALIATION

For her sixth cause of action, Plaintiff incorporates all of her prior allegations and further alleges and states as follows:

159. The matters alleged above constitute retaliation for Plaintiff's use of medical leave under the FMLA, 29 U.S.C. § 2601, *et seq*.

160. Plaintiff was entitled to medical leave under the terms of the FMLA. Plaintiff worked for Defendants, entities with more than fifty (50) employees within a seventy-five (75) mile radius of Plaintiff's work site, for more than one (1) year and for more than one thousand, two hundred and fifty (1250) hours within a one year period prior to her need for leave. When Plaintiff returned from maternity leave under FMLA, Defendants retaliated against her for her use of medical leave, which culminated in Plaintiff's discharge. This retaliation was done in response to Plaintiff exercising her rights under the FMLA.

161. As the direct and proximate result of Defendants' conduct, Plaintiff has suffered injuries and is entitled to recovery of all damages or other relief allowed by the FMLA, including but not limited to lost wages (past and future), liquidated damages, and attorney's fees and costs.

G. SEVENTH CLAIM
WORKERS COMPENSATION RETALIATION

For her seventh cause of action, Plaintiff incorporates all of her prior allegations and further alleges and states as follows:

162. The matters alleged above constitute retaliation for Plaintiff placing her employer on notice of a work related injury.

163. Specifically, Plaintiff was employed by Defendants, was injured during the course of her employment, received treatment under circumstances which should have placed Defendants on notice of her work-related injury, in fact notified Defendants of her work related injury, and was consequently terminated.

164. As damages, Plaintiff has suffered lost earnings, past and future, and other compensatory damages.

165. Because the actions of Defendants were willful, wanton or, at the least, in reckless disregard of Plaintiff's rights, Plaintiff is entitled to punitive damages.

H. EIGHTH CLAIM
VIOLATION OF THE OKLAHOMA MEDICAID FRAUD ACT

For her eighth cause of action, Plaintiff incorporates all of her prior allegations and further alleges and states as follows:

166. This is a claim for treble damages and forfeitures under the Oklahoma Medicaid False Claims Act, Okla. Stat. tit. 63, § 5053.1(B).

167. Defendants have violated the Oklahoma False Claims Act by the following:

a. knowingly presenting, or causing to be presented, to an officer or employee of the State of Oklahoma, a false or fraudulent claim for payment or approval;

b. knowingly making, using, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state;

c. conspiring to defraud the state by getting a false or fraudulent claim allowed or paid;

d. having possession, custody, or control of property or money used, or to be used, by the state and, intending to defraud the state or willfully to conceal the property, delivering, or causing to be delivered, less property than the amount for which the person received a certificate or receipt;

e. being authorized to make or deliver a document certifying receipt of property used, or to be used, by the state and, intending to defraud the state, making or delivering the receipt without completely knowing that the information on the receipt is true;

f. knowingly buying, or receiving as a pledge of an obligation or debt, public property from an officer or employee of the state, who lawfully may not sell or pledge the property; and

g. knowingly making, using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state.

168. By virtue of these payments, the State of Oklahoma has been damaged, and continues to be damaged, in a substantial amount. The State of Oklahoma therefore is entitled to multiple damages under the Oklahoma Medicaid False Claims Act, to be determined at trial, plus a civil penalty of $5,000.00 to $10,000.00 for each violation.

I. NINTH CLAIM
VIOLATION OF THE OKLAHOMA MEDICAID FRAUD ACT (WORKPLACE RETALIATION)

For her ninth cause of action, Plaintiff incorporates all of her prior allegations and further alleges and states as follows:

169. During the course of her employment by Defendants, Plaintiff discovered the above-alleged fraudulent acts that violated both the False Claims Act and the Oklahoma Medicaid False Claims Act.

170. Additionally, Plaintiff voluntarily provided to the United States and the State of Oklahoma information regarding Defendants' fraud.

171. As a result of Plaintiff's discoveries and disclosures to the United States and the State of Oklahoma, Plaintiff's employment with Defendants was terminated.

172. Plaintiff's termination violated OKLA. STAT. tit. 63, § 5053.5.

173. Under that statute, Plaintiff is entitled to reinstatement with the same seniority status, two (2) times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney fees.

VIII.
JURY TRIAL DEMAND

174. Plaintiff demands a trial by jury.

IX.
PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully requests this Court to enter judgment against Defendants as follows:

a. for civil penalties for each false claim, pursuant to 31 U.S.C. § 3729(a);

b. for three times the amount of damages proved, pursuant to 31 U.S.C. § 3729(a);

c. for civil penalties for each false claim, pursuant to OKLA. STAT. tit. 63, § 5053.1(B);

d. for three times the amount of damages proved, pursuant to OKLA. STAT. tit. 63, § 5053.1(B);

e. compensatory damages, back pay, future wages, liquidated damages, emotional distress damages, and punitive damages;

f. two (2) times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees;

g. for the reasonable attorneys' fees, costs, and expenses incurred by Plaintiff in prosecuting this action;

h. for costs of court;

I. for pre-judgment and post-judgment interests at the rates permitted by law; and

j. for such other and further relief as may be appropriate and authorized by law.

Respectfully submitted,

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s/ Tony Gould

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