IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

NEW VISION HOME HEALTH CARE, INC., etc., et al.,

Plaintiffs,

Case No.: 2:16-cv-13173-VAR-RSW

vs.

Hon. Victoria A. Roberts

ANTHEM, INC., etc., et al.,

Mag. Judge R. Steven Whalen

Defendants.

GEORGE F. INDEST III, J.D., M.P.A., LL.M.
CAROLE C. SCHRIEFER, R.N., J.D.
THE HEALTH LAW FIRM
1101 Douglas Avenue
Altamonte Springs, Florida 32714
Phone: (407) 331-6620
Fax: (407) 331-3030
E-mail: GIndest@TheHealthLawFirm.com
Second: CourtFilings@TheHealthLawFirm.com
Attorneys for Plaintiffs

SECOND AMENDED COMPLAINT

Plaintiffs New Vision Home Health Care, Inc., and Saleem Shakoor hereby file their Second Amended Complaint suing Defendants TrustSolutions, LLC (TrustSolutions), Anthem, Inc. (f/k/a WellPoint, Inc.), and National Government Services, Inc. (NGS), (collectively Defendants), referring back in time to the filing

of their original Complaint, stating:

PARTIES AND JURISDICTION

1. At all relevant times hereto, Plaintiff New Vision Home Health Care, Inc. (New Vision), was a Michigan corporation with its principal place of business located in Southfield, Michigan.

2. At all relevant times hereto, Plaintiff Saleem Shakoor was an individual residing in the City of West Bloomfield, County of Oakland, Michigan. At all relevant times hereto Plaintiff Shakoor was and remains the owner, director, sole shareholder and successor in interest to New Vision. Plaintiff Shakoor's interests and Plaintiff New Vision's interests in this matter are one and the same.

3. Defendant TrustSolutions, LLC (TrustSolutions), is a foreign corporation incorporated in Wisconsin. It has its principal place of business located at 120 Monument Circle, Indianapolis, Indiana.

4. On information and belief, TrustSolutions, LLC, is a wholly owned subsidiary of Defendant Anthem, Inc. (f/k/a WellPoint, Inc.) (Anthem), and is completely controlled and operated by Anthem.

5. Anthem is a foreign corporation incorporated in Indiana with its principal place of business located at 120 Monument Circle, Indianapolis, Indiana.

6. On information and belief, at all relevant times, TrustSolutions is and was the alter ego of Anthem. Anthem used TrustSolutions as a mere instrumentality in its abuse of The Centers for Medicare & Medicaid Services' (CMS), Program Safeguard Contractor (PSC) program.

7. Furthermore, Anthem is the successor to TrustSolutions.

8. National Government Services, Inc. (NGS), is a foreign corporation incorporated in Indiana with its principal place of business located at 8115 Knue Road, Indianapolis, Indiana 46250. At all relevant times hereto, NGS was the Medicare Administrative Contractor (MAC) for the Medicare Program for the state of Michigan and for the Plaintiffs.

9. On information and belief, at all relevant times, NGS is and was a wholly owned subsidiary of Anthem, completely controlled and operated by Anthem and was the alter ego of Anthem. Anthem used NGS as a mere instrumentality in its wrongful and unlawful acts as stated herein, including its abuse of the Medicare Appeals Process (MAP) and the Medicare Integrity Program (MIP), to increase Anthem's income.

10. Maximus Federal Services, Inc. (Maximus), is a Virginia corporation with its principal place of business at 1891 Metro Center Drive, Reston, Virginia 20190. At all relevant times hereto, Maximus was the Qualified Independent

Contractor (QIC), pursuant to 42 U.S.C. § 1395ff(c), which was the CMS contractor responsible for the second level of appeal (the "request for reconsideration" or "reconsideration") in the Medicare Appeals Process. While Maximus is not a named party to this complaint, it was involved in the administrative proceedings below and discussed by the Administrative Law Judge (ALJ) in his Decision, Exhibit "1."

11. This Court has mandamus jurisdiction pursuant to 28 U.S.C. § 1361. The Court also has jurisdiction pursuant to 28 U.S.C. § 1332, by virtue of diversity of citizenship, and 28 U.S.C. § 1331, federal question jurisdiction. For those Counts seeking monetary damages, the amount in controversy exceeds $75,000 exclusive of costs, interest and attorney's fees. The Court has jurisdiction pursuant to 28 U.S.C. § 2201 for declaratory relief.

12. Venue is proper in the Eastern District of Michigan, in accordance with 28 U.S.C. §§ 1391(b)(2) and 1391(e)(1)(B), because a substantial part of the events, acts and omissions of the Defendants giving rise to this action occurred in this judicial district and the harm to the Plaintiffs caused by the Defendants took place in this judicial district. Venue is also proper in this district, pursuant to 28 U.S.C. § 1391(e)(1)(C), because Plaintiffs reside in this district. In the alternative, venue is also proper in this district under 28 U.S.C. § 1391(b)(3) because the Defendants are each subject to the court's personal jurisdiction with respect to the Plaintiffs' claims

in this district.

GENERAL ALLEGATIONS COMMON TO ALL COUNTS

A. Plaintiff New Vision

13. At all relevant times hereto, New Vision was a home health agency and provider of Medicare home health services within the meaning of 42 U.S.C. § 1395d(a), providing services paid for under Part A of the Medicare Program. New Vision furnishes home health services to homebound patients, among others.

14. New Vision was a Medicare participating provider. Virtually all of its patients were Medicare beneficiaries. Therefore, New Vision billed Medicare for payment for its services and relied almost exclusively on reimbursement from Medicare.

B. CMS and NGS

15. The Centers for Medicare and Medicaid Services (CMS) is a division within the U.S. Department of Health and Human Services (HHS), a federal agency. It is responsible for the administration and operation of the Medicare program, including contracting with private business entities and insurance companies to assist in carrying out its functions.

16. At all relevant times hereto, NGS was the Medicare Administrative Contractor (MAC) for the State of Michigan, having been contracted by CMS to process Medicare claims.

17. After rendering services to Medicare beneficiaries, New Vision would submit its claims for payment under Medicare to NGS.

18. As a MAC, NGS was responsible for "[d]etermining the amount of payments to be made to providers for covered services furnished to Medicare beneficiaries" and "[m]aking the payments." 42 C.F.R. § 421.100(a).

19. At all relevant times in this matter, NGS held a contract with CMS pursuant to the Medicare Integrity Program. 42 U.S.C. § 1395ddd.

C. TrustSolutions and Anthem

20. At all relevant times, TrustSolutions was a Medicare Program Safeguard Contractor ("PSC").[1] In this role it contracted with CMS to perform program integrity functions such as detecting and deterring potential waste, fraud and abuse

[1] In 2012 the name used for Program Safeguard Contractors was changed to Zone Program Integrity Contractors (ZPICs). At all times relevant hereto TrustSolutions was the PSC or ZPIC acting against the Plaintiffs. The purpose of the PSC or ZPIC is to detect and recover for fraudulent claims billed to Medicare. They are financially rewarded by CMS based on the amount of allegedly fraudulent claims they identify. See n. 8, infra.

in the Medicare program.

21. At all relevant times in this matter, TrustSolutions held a contract with CMS pursuant to the Medicare Integrity Program. 42 U.S.C. § 1395ddd.

22. On information and belief, Anthem is the largest for-profit managed health care company in the Blue Cross Blue Shield Association.

23. Anthem acquired WellPoint Health Networks, Inc., with the combined company adopting the name WellPoint, Inc., on November 30, 2004. Effective December 2, 2014, WellPoint changed its corporate name to Anthem, Inc.

24. On information and belief, during the time period in which New Vision's claims arise, Anthem used TrustSolutions for its own benefit as a mere instrumentality.

25. In doing so, Anthem failed to observe corporate formalities such that there was no distinction between the two entities due to Anthem's control over TrustSolutions' execution of its day-to-day operations.

26. On information and belief, Anthem exercised direct control over the management, directors, and officers of TrustSolutions to advance its own interests and policies.

27. TrustSolutions functioned as the alter ego of Anthem for purposes of pursuing Anthem's unlawful objectives through the PSC program.

28. All profits and benefits obtained by TrustSolutions through its actions as stated herein actually accrued to and were retained by Anthem.

29. Anthem was an interested party in the Plaintiffs' case having a substantial financial interest in the outcome, along with TrustSolutions, in violation of the independence standards required by 42 U.S.C. §§ 1395ff(g)(2) and (5), at all times that New Vision was being reviewed by TrustSolutions.

30. Anthem was an interested party in the Plaintiffs' case, having a substantial financial interest in the outcome, along with NGS, in violation of the independence standards required by 42 U.S.C. §§ 1395ff(g)(2) and (5), at all times that New Vision was being reviewed by NGS.

D. The Medicare Appeals Process

31. First Step. If a claim submitted by a Medicare provider is denied (in whole or in part), the Medicare provider may appeal the denial to the Medicare Administrative Contractor (MAC) (in this case, for New Vision it was NGS). The first appeal is called a "request for redetermination." The request for redetermination is submitted to the MAC that originally denied the claim or demanded the refund of the alleged overpayment amount.

32. Second Step. If a claim is denied (in whole or in part) by the MAC upon

its redetermination, the Medicare provider may then appeal the decision to a Qualified Independent Contractor (QIC) (in this case, for New Vision it was Maximus), which is supposed to be a separate, independent entity contracted by CMS for that purpose. This second appeal is called a "request for reconsideration."

33. Third Step. If the claim is denied (in whole or in part) by the QIC upon the reconsideration, the Medicare provider may then appeal the decision further by requesting a formal administrative hearing before an administrative law judge (ALJ) of the U.S. Department of Health and Human Services' (HHS) Office of Medicare Hearings and Appeals (OMHA).[2] The ALJ's decision is final unless any party requests further review by the Medicare Appeals Council within sixty (60) days. 42 C.F.R. § 405.1048.

34. Fourth Step. If any party to the ALJ hearing is dissatisfied with the decision of the ALJ that is issued after the hearing, then that party may appeal the case to the Medicare Appeals Council within sixty (60) days. After this period of time has passed with no appeal, the ALJ's decision becomes final. 42 C.F.R. § 405.1048. An organization called the Departmental Appeals Board (or DAB)

---

[2] Because of the numerous abbreviations and acronyms for the different organizations and processes involved in this complex matter, many of which change over time and some of which are the same as others (e.g., "MAC" for "Medicare Administrative Contractor" and "MAC" for Medicare Appeals Council), Plaintiff will attempt to limit use of such abbreviations in favor of the full names.

manages and acts for the Medicare Appeals Council.

35. Fifth Step. Review by the federal district court.[3]

E. New Vision's Audits and Appeals

36. On July 31, 2007, TrustSolutions initiated a post-payment review or audit for New Vision's Medicare claims for dates of service from May 8, 2003, through October 3, 2006. These were claims paid by NGS from January 1, 2004 to December 10, 2006. Exhibit "1."[4]

37. There were claims for 228 episodes of home health care provided to 186 Medicare beneficiaries in this audit. (Exhibit "1," pp. 2-3 & 271-273.)

38. On August 14, 2008, TrustSolutions denied approximately ninety percent

---

[3] See 42 U.S.C. § 1395ff and 42 C.F.R. §§ 405.900 to 405.1140. See generally PrimeSource Healthcare of Ohio, Inc. v. Sebelius, 2014 U.S. Dist. LEXIS 93293, 2014 WL 3368194 (N.D. Ill. Jul. 9, 2014). However, in this case, since there was no appeal to the Medicare Appeals Council after the ALJ Decision of September 4, 2013, the last step actually exercised in the administrative appeal process at issue herein was the ALJ hearing, for which the resulting decision was favorable to the Plaintiffs and was not further appealed. It is Exhibit "1" to this Second Amended Complaint.

[4] The Decision of U.S. Administrative Law Judge James S. O'Leary, dated September 4, 2013, in HHS Office of Medicare Hearings and Appeals, Case No. 1-909525621, is attached with certain patient information redacted from it so as to protect privacy of the Medicare beneficiaries. The redacted information is not directly relevant to this litigation.

(90%) of the claims reviewed (which had previously been paid). (Exhibit "1," pg. 3.) It found that New Vision had received a total of $672,493.57 in actual overpayments for only those claims in the audit sample it reviewed.

39. TrustSolutions then used a statistical extrapolation formula to calculate an estimated total overpayment by Medicare to New Vision of $4,155,239.00, during the period covered by the audit (May 8, 2003, through December 10, 2006). (Exhibit "1," pp. 4 & 20).

40. New Vision timely appealed the denied claims through the Medicare Appeals Process, ultimately having the decision reversed for more than ninety-nine percent (99%) of the denied claims.

41. However, in October 2010, while New Vision was still in the Medicare Appeals Process, NGS began recoupment on the alleged overpayment of $4,155,239.00 from New Vision.

42. From October 2010 through the present time, NGS has not paid any claims, including back claims, or refunded any amount owed by Medicare to New Vision.

43. New Vision timely and properly utilized the Medicare Appeals Process. New Vision eventually obtained the current Administrative Law Judge Decision in its favor on September 4, 2013, thus completely exhausting its administrative

remedies. Exhibit "1."[5]

F. The Administrative Law Judge's Decision of September 4, 2013

44. In the present case, New Vision went through every step in the Medicare Appeals Process. It received an ALJ decision that was in its favor on ninety-nine percent (99%) of the denied claims it appealed to the ALJ. Exhibit "1."

45. In the decision dated September 4, 2013, Exhibit "1," Administrative Law Judge James S. O'Leary overturned TrustSolutions' statistical sampling as invalid. (Exhibit "1," pp. 14, 268, 294-299, 300-305).

46. The ALJ's decision was entered on September 4, 2013. Exhibit "1." The ALJ's Decision was not appealed to the Medicare Appeals Council. Therefore, on

---

[5] The procedural history of these claims through the Medicare Appeals Process is extremely complex and convoluted. It involved multiple appeals, remands and ALJ hearings. The original ALJ decision dated October 18, 2011, favorable to New Vision, was appealed to the Medicare Appeals Council (note: the Departmental Appeals Board or "DAB" operates the Medicare Appeals Council or MAC) by the Administrative Qualified Independent Contractor. (Exhibit "1," pg. 12.) The Medicare Appeals Council/DAB remanded the case to the ALJ for a new hearing. (Exhibit "1," pg. 12.) The ALJ held another hearing and issued the decision for which enforcement is being sought herein on September 4, 2013, finding that more than ninety-nine percent (99%) of the denied claims were valid and ordering the contractors to pay all of New Vision's claims that had been denied or recouped. No party requested further review of the ALJ Decision of September 4, 2013. Thus it became final on November 3, 2013. 42 C.F.R. § 405.1048. A detailed chronology of the case is provided by the ALJ as Appendix C to Exhibit "1."

November 3, 2013, the ALJ's decision, Exhibit "1," became final. 42 C.F.R. § 405.1048;[6] Medicare Claims Processing Manual, Ch. 29, § 340.[7]

47. The final paragraph of Judge James S. O'Leary's Decision states in part:

ORDER

> The Medicare contractors [sic] are hereby **DIRECTED** [sic] to process the claims and claim lines at issue in accordance with this decision. Any amounts recouped or otherwise recovered from the Provider [New Vision] based upon the invalid overpayment demands herein shall be returned to the [a]ppellant.

Exhibit "1," pg. 305 (emphasis in original).

48. The ALJ's Decision was forwarded by the Administrative Qualified Independent Contractor (AdQIC) to both NGS and CMS for compliance with it as shown by subsequent correspondence between NGS, CMS and the Plaintiffs.

49. As of the date of this Second Amended Complaint, none of the Defendant contractors nor CMS has complied with the ALJ's Decision of September 4, 2013, Exhibit "1."

50. As of the date of this Second Amended Complaint, the Defendants

---

[6] See also, CMS, Medicare Financial Management Manual, CMS Pub. 100-06, Ch. 3.

[7] CMS, Medicare Claims Processing Manual, CMS Pub. 100-04, Ch. 29, § 340.

continue to not pay claims submitted by Plaintiffs claiming they are recouping funds overpaid.

51. As of the date of this Second Amended Complaint, none of the Defendant contractors nor CMS has repaid New Vision the amount of the wrongfully denied claims as calculated by the ALJ in his Decision of September 4, 2013 (Exhibit "1," pp. 4 & 305.)

52. As of the date of this Second Amended Complaint, none of the payments or recouped amounts that were the subject of the ALJ hearing have been refunded to Plaintiffs by Defendants.

G. ALJ's Findings Incorporated Herein

53. The ALJ's Decision of September 4, 2013, Exhibit "1" and all of its findings and conclusions are adopted herein by reference. The chronology attached to the ALJ's Decision, Appendix C of Exhibit "1," is incorporated herein and provides a more detailed factual basis giving the background of this matter.

54. As stated in 42 C.F.R. § 405.1048, "the decision of the ALJ is binding on all parties. . . ."

H. Conditions Precedent Satisfied

55. All conditions precedent to bringing this litigation have been fulfilled, complied with or waived.

56. Plaintiffs have fully and completely exhausted all administrative remedies connected with their allegations made herein, including but not limited to, fully completing all steps required of them in the Medicare Appeals Process.

57. No exception stated in 42 C.F.R. § 405.1048 applies in this case.

58. Furthermore, Plaintiffs have no other remedy available to them to obtain relief in this matter, other than as stated herein.

I. Entitlement to Interest, Attorney's Fees and Costs

59. Plaintiffs are entitled to interest on all claims amounts owed to it as calculated in the ALJ's Decision, pursuant to 42 U.S.C. § 1395g(d); the Medicare Financial Management Manual, Pub. 100-06, Ch. 3; and the Medicare Claims Processing Manual, Ch. 29, § 330.6. Id.

60. Plaintiffs are entitled to their attorney's fees, costs and expenses pursuant to 28 U.S.C. § 2412(a)(1) and 5 U.S.C. § 504.

COUNT I

PETITION FOR WRIT OF MANDAMUS FOR ENFORCEMENT OF ALJ'S DECISION OF SEPTEMBER 4, 2013

(Contractors Within Course and Scope)

61. This is a cause of action for a writ of mandamus by the Plaintiffs against all three (3) Defendants to enforce the Administrative Law Judge's Decision of September 4, 2013, Exhibit "1."

62. This Count is pleaded in the alternative to and in addition to all other Counts in this Complaint.

63. Paragraphs 1 through 60 above are incorporated herein by reference.

64. Both Plaintiffs have an interest that is required to be protected by the action requested herein.

65. For purposes of this Count and this Count alone, Plaintiffs allege that at all times relevant hereto, the Defendants were acting lawfully and within the course and scope of their duties as contractors and agents of the government, notwithstanding the findings in the ALJ's Decision.

66. For purposes of this Count and this Count alone, Plaintiffs allege that at all times relevant hereto, the Defendants were carrying out the terms of their contracts and were exercising due care, notwithstanding the findings in the ALJ's Decision.

67. As of this date, the Defendants have failed to comply with the ALJ's Decision.

68. Furthermore, since October 2010, pursuant to the instructions of Defendant TrustSolutions, Defendant NGS has paid none of the claims submitted for payment by the Plaintiffs and has continued to illegally recoup the $4,155,239.00 alleged overpayment (that was reversed by the ALJ) from the money it owes Plaintiffs, despite a statutory obligation to do so.

69. This Court has mandamus jurisdiction to enforce such decisions under 28 U.S.C. § 1361. Farkas v. Blue Cross Blue Shield of Mich., 24 F.3d 853 (6th Cir. 1994); PrimeSource Healthcare of Ohio, Inc. v. Sebelius, 2014 U.S. Dist. LEXIS 93293, 2014 WL 3368194 (N.D. Ill. Jul. 9, 2014).

70. Plaintiffs have a clear legally and judicially protected right to the relief sought from the Defendants.

71. The Defendants owe the Plaintiffs performance of the legal duty sought to be compelled that is so plainly prescribed as to be free from doubt.

72. The Defendants have a clear legal duty to perform.

73. At this point, the act for which mandamus is sought is a specific, plain ministerial act devoid of exercise of judgment or discretion.

74. The duty owed by the Defendants to the Plaintiffs is mandatory and not

discretionary.

75. Plaintiffs have no other adequate legal or equitable remedy available to obtain relief.

WHEREFORE, for the purposes of this Count, Plaintiffs request the Court:

A. Issue a writ of mandamus against the Defendants ordering their immediate compliance with the Administrative Law Judge's decision of September 4, 2013, Exhibit "1."

B. Alternatively, the Defendants should be required to take whatever action may be necessary in their role as government contractors to have the government make all payments that are due to the Plaintiffs pursuant to the Administrative Law Judge's decision of September 4, 2013.

C. In addition, Plaintiffs request the Court to include an assessment of interest, attorney's fees, costs and expenses against the Defendants in accordance with the authority cited in paragraphs 54 and 55 above from October 2010 until paid in full.

COUNT II

PETITION FOR WRIT OF MANDAMUS FOR ENFORCEMENT OF ALJ'S DECISION OF SEPTEMBER 4, 2013

(Contractors Outside of Course and Scope and Failed to Exercise Due Care)

76. This is a cause of action for a writ of mandamus by the Plaintiffs against all three (3) Defendants to enforce the Administrative Law Judge's decision of September 4, 2013, Exhibit "1."

77. This Count is pleaded in the alternative to and in addition to all other Counts in this Complaint.

78. Paragraphs 1 through 60 above are incorporated herein by reference.

79. Plaintiffs have an interest that is required to be protected by the action requested herein.

80. For purposes of this Count Plaintiffs allege that at all times relevant hereto the Defendants were acting outside the course and scope of their duties as contractors and agents of the government and without due care.

81. For purposes of this Count Plaintiffs allege that at all times relevant hereto the Defendants violated the terms of their contracts with the government and failed to exercise due care in the performance of their duties.

82. Plaintiffs further incorporate the allegations made in paragraphs 67

through 75 above.

WHEREFORE, for the purposes of this Count, Plaintiffs request the Court:

A. Issue a writ of mandamus against the Defendants ordering their immediate compliance with the Administrative Law Judge's decision of September 4, 2013, Exhibit "1."

B. Alternatively, the Court should find the Defendants liable in accordance with the ALJ's determination of the amounts wrongfully withheld from the Plaintiffs jointly, severally and individually.

C. In addition, Plaintiffs request the Court to include an assessment of interest, attorney's fees, costs and expenses against the Defendants in accordance with the authority cited in paragraphs 54 and 55 above from October 2010 until paid in full.

COUNT III

NEGLIGENCE

(Against All Defendants)

83. This is a cause of action for damages for the negligence of all three (3) Defendants, arising under Michigan law, within the jurisdiction of this Court.

84. This Count is pleaded in the alternative to and in addition to all other

Counts in this Complaint.

85. Paragraphs 1 through 60 above are incorporated herein by reference.

86. At all times relevant hereto Defendants were acting outside the course and scope of their contracts with CMS, were not acting with due care, and were knowingly violating applicable laws and regulations.

87. Plaintiffs presented the claims stated in this Count to the relevant government agency and to the Defendants named herein and such claims were administratively litigated to finality as shown, in part by Exhibit "1." Plaintiffs have exhausted their administrative remedies for the claims stated in this Count.

88. Alternatively, it is alleged that the wrongful actions taken by the Defendants as stated herein and the claims made by the Plaintiffs in this Count did not arise under the Medicare Act, 42 U.S.C. § 1395, et seq.

A. Hidden Purpose Motivating Defendants' Actions; Bonuses Paid to Contractors for Denied Claims; and Conflicts of Interest

89. At all times relevant hereto, PSC/ZPIC contractors such as TrustSolutions received an incentive bonus (or "awards payment") based on the amount of claims of Medicare providers it determined to be false, fraudulent or

otherwise overpayments.[8]

90. During the period at issue, TrustSolutions working with NGS, routinely improperly denied 100% of the Medicare claims that had been paid to home health providers to increase its overpayment rates for the purpose of receiving awards payments (incentive bonuses) from CMS.

91. On information and belief, at all relevant times hereto Anthem promulgated and advanced a corporate policy of using its Program Safeguard Contractor subsidiaries, such as TrustSolutions, to audit New Vision in violation of Medicare policies and procedures.

92. Anthem's intent in doing this was to artificially increase the alleged overpayments it identified as having been paid to Medicare providers, including the Plaintiffs, so as to maintain and gain additional contracts with CMS. Such contracts included those for Recovery Audit Contractors (RACs) and Zone Program Integrity Contractors (ZPICs).

---

[8] See Wheeler, et al., "Meet the Fraud Busters: Program Safeguard Contractors and Zone Program Integrity Contractors," 4 J. Health & Life Sci. L. 1 at 5, No. 2, (Feb 2011); and U.S. GAO, "Medicare Program Integrity: Contractors Reported Generating Savings, but CMS Could Improve its Oversight," (Oct. 2013) (GAO-14-111), at 12-13, which reports, in part: "Each ZPIC contract includes award fee provisions, which give contractors the opportunity to earn all or some of the award fee. . . . CMS paid the six operating ZPICs . . . in calendar year 2012 . . .about $1.3 million in award fees for each ZPIC's most recent contract year evaluation. . . . [Emphasis added.]

93. Anthem did this to wrongfully increase its profits, since ZPICs, RACs and PSCs receive contingent bonuses based on their recoveries of overpayments from Medicare providers such as New Vision, which would then accrue to Anthem, their owner. Fees paid by CMS to its contractors, including TrustSolutions and NGS, accrued to their owner, Anthem.

94. Additionally, by owning both the Medicare Administrative Contractor (MAC), NGS, and the Zone Program Integrity Contractor (ZPIC), TrustSolutions, two organizations which should have been independent of each other and both of which had jurisdiction over New Vision, Anthem created a conflict of interest by its common ownership and control.

95. The foregoing constitutes a hidden purpose and an improper motive for the actions taken by the Defendants.

B. Failure to Act with Due Care; Lack of Immunity

96. For purposes of this Count, Plaintiffs allege that at all times relevant hereto, the Defendants were acting outside of the course and scope of their duties as contractors and agents of the government and were acting unlawfully, in direct violation of federal laws, federal regulations, and mandatory Medicare procedures and guidelines.

97. The Defendants did not exercise due care, failed to comply with CMS guidelines in its relations with New Vision, and did not follow CMS directives from the Medicare Program Integrity Manual. Thus the Defendants, by federal law, are not entitled to immunity for the wrongs alleged in this Count.

98. Defendants are not immune from liability for the cause of action stated in this Count. 42 U.S.C. §§ 1395ddd(e) & 1320c-6(b); & 42 C.F.R. § 421.316(a).[9]

---

[9] The federal statute which created the Medicare Integrity Program (MIP) states at 42 U.S.C. § 1395ddd(e):

> **(e) Limitation on contractor liability.**
> The Secretary [of the Department of Health and Human Services] shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1320c–6 of this title.

42 U.S.C. § 1320c-6 states:

> **(b) Employees and fiduciaries of organizations having contracts with Secretary.**
> No organization having a contract with the Secretary under this part and no person who is employed by, or who has a fiduciary relationship with, any such organization or who furnishes professional services to such organization, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this part or to a valid contract entered into under this part, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) provided due care was exercised in the performance of such duty, function, or activity. [Emphasis added.]

It should be noted that in establishing the immunity provisions contained in the Medicare Integrity Program regulations, the Centers for Medicare and Medicaid Services, Department of Health and Human Services, stated at 72 Fed. Reg. 48869, 48878 (Aug. 24, 2007):

> In drafting §421.316(a), we considered employing a standard for the limitation of liability other than the due care standard. For example, we considered whether it would be appropriate to provide that a contractor would not be criminally or civilly liable by reason of the performance of any duty, function, or activity under its contract provided the contractor was not grossly negligent in that performance. However, section 1893(e) of the Act requires that we employ the same or comparable standards and provisions as are contained in section 1157 of the Act. We do not believe that it would be appropriate to expand the scope of immunity to a standard of gross negligence, as it would not be a comparable standard to that set forth in section 1157(b) of the Act. [Emphasis added.]

CMS went on to further clarify this stating at 72 Fed Reg. 48869, 48879 (Aug. 24, 2007):

> . . . We believe that the due care standard specified in §421.316(a) is the only standard consistent with the statutory mandate of the Act. Section 1893(e) of the Act requires us to limit a contractor's liability by employing the same or comparable standards that are set forth in section 1157 of the Act. Section 1157 of the Act limits a contractor's liability under a due care standard. We believe that applying this standard to MIP contractors strikes a reasonable balance between the concerns of the contractors and those subject to the contractors' review. We believe MIP contractors operate with due care to avoid liability, and those being reviewed [e.g., Plaintiffs in this case] have the assurance that they have legal recourse if a contractor

C. Concert of Action

99. The three (3) Defendants each acted in concert with each other and pursuant to a common design.

100. Defendants each aided and abetted the other in carrying out the activities stated herein.

101. Defendants each were engaged in tortious conduct.

102. Defendants are each liable for all of the tortious, wrongful conduct alleged herein and are each liable for the damages set forth herein.

D. Negligence Acts and Omissions

103. Defendants committed a number of negligent and wrongful acts and omissions and failed to exercise due care as set forth herein.

104. Defendants violated a number of federal statutes and regulations as set forth herein, including but not limited to:

a. Defendants committed wrongful acts in initiating the post-payment audit and statistically extrapolating the audit findings given the nearly fully favorable pre-payment review results in favor of New Vision and that there was not a sustained

---

acts negligently. [Emphasis added.]

or high level of payment error or showing that documented educational intervention failed to correct the payment error, in violation of 42 U.S.C. § 1395ddd(f)(3).

b. Defendants committed wrongful acts by failing to comply with the Medicare Program Integrity Manual and Medicare Financial Management Manual, both having the force of regulations.

c. Defendants' post-payment audit, statistical extrapolation and review on appeal were undertaken in violation of the Social Security Act, federal regulations and controlling CMS guidelines, as stated above.

d. Violating 42 U.S.C. §1395ddd(f)(7) (Title XVIII §1893(f)(7) of the Social Security Act or the "Act"), which requires Medicare contractors to provide a supplier or provider audited through a post-payment audit with written notice of the contractor's intent to conduct an audit and to present a full review and explanation of the findings of the audit upon its completion.

e. Violating 42 U.S.C. § 1395ddd(f)(3) (§1893(f)(3) of the Act), which prohibits use of extrapolation to determine overpayment amounts unless the Secretary determines that "(A) there is a sustained or high level of payment error; or (B) documented educational intervention has failed to correct the payment error." Id.

f. Violating the Medicare Financial Management Manual, which requires Medicare audits to comply with Government Auditing Standards. (CMS,

Medicare Financial Management Manual, CMS Pub. 100-06, Ch. 8, § 80.)

g. Violating the Medicare Program Integrity Manual[10] provides mandatory directives Medicare contractors must follow when conducting post-payment audits and statistical sampling and extrapolation. (CMS, Medicare Program Integrity Manual, Ch. 3.)

h. Violating 42 U.S.C. §§ 1395ddd(f) & (7) (§§ 1893(f)(3) and (7) of the Act) by failing to comply with CMS guidelines in initiating and conducting the post-payment audit and statistical extrapolation of New Vision's billed services.

i. Additionally, Anthem and TrustSolutions violated the independence standards required by 42 U.S.C. §§ 1395ff(g)(2) and (5), at all times that New Vision was being reviewed by TrustSolutions, because Anthem was an interested party in the Plaintiffs' case having a substantial financial interest in the outcome, along with TrustSolutions.

105. Under Michigan law, the violation of statutes or regulations give rise to a presumption of negligence on the part of the Defendants.

106. Additionally, Defendants, in their reviews and audits, failed to comply with generally accepted government auditing standards and generally accepted statistical practice and procedures, as set forth in greater detail above and in the ALJ

[10] CMS, Medicare Program Integrity Manual, SMS Pub. 100-08,

Decision attached as Exhibit "1".

107. Defendants had a duty or duties to the Plaintiffs as set forth, in part, in the statutes and regulations governing the Medicare Program and the Medicare Appeals Process (MAP).

108. Defendants breached their duty or duties to the Plaintiffs in one or more ways as set forth herein.

109. Plaintiffs were harmed as a direct result of their breaches.

E. New Vision's Growth and Business and Its Decline

110. New Vision became an enrolled Medicare provider of home health services with CMS in February of 2002.

111. As a result of its hard work and provision of quality services, New Vision flourished and grew as a home health provider.

112. New Vision grew from one (1) office in 2002 to three (3) offices in 2006, because of its reputation and quality of services.

113. New Vision had an average of approximately 150 to 170 active Medicare patients in 2006.

114. New Vision's income grew to approximately $3,000,000 by 2006.

F. Plaintiffs' Damages

115. As of 2010, New Vision had fewer than 50 referring providers, which exists through this date.

116. As a result of the post-payment audit, in or about December 2010, New Vision had terminated nearly all of its employees as it no longer had the financial ability to maintain payroll, New Vision had lost nearly all of its patients and customers, and New Vision had lost the overwhelming majority of its referring providers.

117. In or about 2011, New Vision lost the majority of its patients so that it had only seven (7) active patients. As of this date, New Vision has had to close all of its offices except for the one (1) office it has remaining.

118. In 2013, New Vision's annual income had dropped to $2,604.46. Its income for the years from 2014 through the present has been similar or less.

119. Physicians and hospitals ceased referring patients to New Vision.

120. As a direct result of the Defendants' acts as set forth in this Count, Plaintiffs suffered the following noninclusive damages:

a. Closure of offices;

b. Loss of referral sources;

c. Loss of its patients and clients;

d. Loss past of income and profit;

e. Loss of their professional reputation;

f. Loss of future income and profits; and

g. Loss of opportunities for growth and expansion.

121. Plaintiffs estimate that they have lost in excess of $20,000,000.00 in past and future lost business profits alone.

122. As a result of Defendants' wrongful acts, New Vision lost essentially all of its business, suffered in excess of $20,000,000.00 in lost business profits and incurred over $400,000.00 in legal and expert fees challenging the wrongful post-payment audit findings.

123. Defendants' wrongful and improper actions as stated above directly caused or resulted in Plaintiffs' damages as set forth in detail in Paragraphs115 through 122 above, incorporated herein by reference.

WHEREFORE, for the purposes of this Count, Plaintiffs request the Court enter judgment in their favor against the Defendants, jointly, severally and in individually for:

A. Pre-judgment interest on all liquidated amounts.

B. Monetary damages for all past and future losses.

C. Their attorney's fees and costs.

D. Post-judgment interest.

E. Any other relief the Court finds to be fair and equitable.

COUNT IV

GROSS NEGLIGENCE

124. This is a cause of action for damages for gross negligence against all three (3) Defendants for violating statutes and regulations, arising under Michigan law, within the jurisdiction of this Court.

125. This Count is pleaded in the alternative to and in addition to all other Counts in this Complaint.

126. Paragraphs 1 through 60 and 89 through 113 above are incorporated herein by reference.

127. At all times relevant hereto Defendants were acting outside the course and scope of their contracts with CMS, were not acting with due care, and were knowingly violating applicable laws and regulations.

128. Plaintiffs presented the claims stated in this Count to the relevant government agency and to the Defendants named herein and such claims were administratively litigated to finality as shown, in part by Exhibit "1." Plaintiffs have exhausted their administrative remedies for the claims stated in this Count.

129. Alternatively, it is alleged that the wrongful actions taken by the Defendants as stated herein and the claims made by the Plaintiffs in this Count did not arise under the Medicare Act, 42 U.S.C. § 1395, et seq.

130. Defendants committed willful and wrongful misconduct in their actions as set forth herein.

131. In addition to other actions, Defendants initiated a post-payment review on the Plaintiffs for claims previously submitted and paid from 2004 to 2006. Defendants then applied a statistical extrapolation formula to their review findings, despite the requirements not being met to do so, in violation of 42 U.S.C. § 1395ddd(f)(3) (§1893(f)(3) of the Act).

132. Defendants were also willful and wanton in initiating the post-payment review of the Plaintiffs claims, when the requirements for this were not met.

133. Defendants had a duty or duties to the Plaintiffs as set forth, in part, in the statutes and regulations governing the Medicare Program and the Medicare Appeals Process.

134. Defendants willfully and wantonly breached their duty or duties to the Plaintiffs in one or more ways as set forth herein.

135. Plaintiffs were harmed as a direct result of their breaches.

136. Defendants' wrongful and improper actions as stated above directly

caused or resulted in Plaintiffs' damages as set forth in detail in Paragraphs 115 through 122 above, incorporated herein by reference.

WHEREFORE, for the purposes of this Count, Plaintiffs request the Court enter judgment in their favor against the Defendants, jointly, severally and in individually for:

A. Pre-judgment interest on all liquidated amounts.

B. Monetary damages for all past and future losses.

C. Their attorney's fees and costs.

D. Post-judgment interest.

E. Any other relief the Court finds to be fair and equitable.

COUNT V

TORTIOUS INTERFERENCE WITH BUSINESS RELATIONSHIPS AND EXPECTANCIES
(Against All Defendants)

137. This is a cause of action for tortious interference with business relationships and expectancies, arising under Michigan law, for monetary damages within the jurisdiction of this Court, by the Plaintiffs against all three (3) Defendants.

138. This Count is pleaded in the alternative to and in addition to all other Counts in this Complaint.

139. Paragraphs 1 through 60 and 89 through 113 above are incorporated herein by reference.

140. At all times relevant hereto Defendants were acting outside the course and scope of their contracts with CMS, were not acting with due care, and were knowingly violating applicable laws and regulations.

141. Plaintiffs presented the claims stated in this Count to the relevant government agency and to the Defendants named herein and such claims were administratively litigated to finality as shown, in part by Exhibit "1." Plaintiffs have exhausted their administrative remedies for the claims stated in this Count.

142. Alternatively, it is alleged that the wrongful actions taken by the Defendants as stated herein and the claims made by the Plaintiffs in this Count did not arise under the Medicare Act, 42 U.S.C. § 1395, et seq.

143. New Vision had profitable business relationships with third parties.

144. New Vision also had the expectancy of additional profitable business relationships with third parties.

145. The third parties referred to above include, but were not limited to:

a. Its clients and patients;

b. Physicians who referred patients to New Vision for services and wrote orders (or prescriptions) for its services;

c. Hospitals and health systems, including but not limited to, Detroit Medical Center, Beaumont, Henry Ford, Hurley, McLaren;

d. Assisted living facilities and skilled nursing facilities which referred patients/clients to New Vision.

146. New Vision had a robust network of referring providers including physicians and physician groups and discharge planners in hospitals and other health facilities.

147. In 2006, during the time of the pre-payment review, New Vision had established business relationships with over 150 referring providers.

148. The Defendants had actual knowledge of the business relationships and expectations stated above.

149. All of New Vision's business came through its business relationships stated above.

150. By virtue of TrustSolutions's and NGS's roles as Medicare Integrity Program (MIP) contractors, Defendants were aware that New Vision had a relationship and continued business expectancy with CMS as an enrolled provider of Medicare services. Additionally, by virtue of TrustSolutions's and NGS's roles as MIP contractors, Defendants were aware of New Vision's relationship and continued business expectancy with its Medicare patients and extensive network of referring

providers.

151. Despite their knowledge of these relationships and business expectancies, Defendants knowingly, intentionally and improperly interfered with these relationships and business expectancies, inducing and causing a disruption and termination in these relationships and business expectancies.

152. Acts by the Defendants included, but are not limited to:

a. "Fraud Investigators" from TrustSolutions sought out existing patients of Plaintiffs and informed them that New Vision had committed Medicare fraud. This alarmed and disturbed these patients who then obtained services elsewhere.[11]

b. "Fraud Investigators" from TrustSolutions went to physicians offices who were existing referral sources for New Vision and informed physicians and their employees that New Vision had committed Medicare fraud. This caused those physicians and physician groups to stop referring patients to New Vision.

c. "Fraud Investigators" from TrustSolutions went to healthcare facilities that referred patients to New Vision and informed their employees that New

---

[11] See, for example, GAO, Medicare Program Integrity: Contractors Reported Generated Savings, but CMS Could Improve Oversight (Oct. 23, 2013), available at http://www.gao.gov/assets/660/658565.pdf, pg. 33, Appendix II (In 2012, ZPICs conducted 3,658 patient interviews).

Vision had committed Medicare fraud. This caused those facilities to stop referring patients to New Vision.

d. One of TrustSolutions' managers, B.S., while speaking with the Director of Nursing of New Vision, T.W., its employee, told the Director of Nursing in a number of different telephone conferences from March through August 2007, that New Vision had committed Medicare fraud and "We are shutting you down." This upset that employee, caused panic among New Vision's employees, and employees left and caused employees to leave and find jobs elsewhere.

153. Defendants also:

a. Knew that wrongfully asserting an overpayment for the extrapolated amount of $4,155,239.00 and wrongfully upholding the denial of claims on appeal at the redetermination level against New Vision would interfere with New Vision's business relationships and expectancies with CMS, referring providers and Medicare patients.

b. Persisted in their post-payment audit, statistical extrapolation and review on appeal, which were undertaken with the purpose of unlawfully interfering in New Vision's business relationships and expectancies with CMS, with their referring providers and with their Medicare beneficiaries (patients), with the self-serving, improper, unethical and fraudulent purpose of securing future CMS

contracts, including as future RACs, MACs and ZPICs.

154. Defendants' intentional, improper and wrongful interference resulted in New Vision's damages.

155. As shown by the allegations set forth above:

a. The Defendants intentionally and improperly interfered with the business relationships and expectancies of the Plaintiffs.

b. The Defendants induced and caused breaches, disruptions and terminations of the business relationships and expectancies of the Plaintiffs.

c. The wrongful actions of the Defendants resulted in damages to the Plaintiffs from the breaches, disruptions and terminations of the business relationships and expectancies stated above.

156. Defendants' wrongful and improper actions as stated above directly caused or resulted in Plaintiffs' damages as set forth in detail in Paragraphs 115 through 122 above, incorporated herein by reference.

WHEREFORE, for the purposes of this Count, Plaintiffs request the Court enter judgment in their favor against the three (3) Defendants, jointly, severally and in individually for:

A. Pre-judgment interest on all liquidated amounts.

B. Monetary damages for all past and future losses.

C. Their attorney's fees and costs.

D. Post-judgment interest.

E. Any other relief the Court finds to be fair and equitable.

COUNT VI

VIOLATION OF RIGHT TO PROCEDURAL DUE PROCESS

157. This is a cause of action for violation of the Plaintiffs' right to due process of law pursuant to the Fifth Amendment of the U.S. Constitution and Article I, Section 17 of the Constitution of Michigan. It is a claim for monetary damages within the jurisdiction of this Court, by the Plaintiffs against all three (3) Defendants.

158. This Count is pleaded in the alternative to and in addition to all other Counts in this Complaint.

159. Paragraphs 1 through 60 and 89 through 113 above are incorporated herein by reference.

160. At all times relevant hereto Defendants were acting outside the course and scope of their contracts with CMS, were not acting with due care, and were knowingly violating applicable laws and regulations.

161. Plaintiffs presented the claims stated in this Count to the relevant

government agency and to the Defendants named herein and such claims were administratively litigated to finality as shown, in part by Exhibit "1." Plaintiffs have exhausted their administrative remedies for the claims stated in this Count.

162. Alternatively, it is alleged that the wrongful actions taken by the Defendants as stated herein and the claims made by the Plaintiffs in this Count did not arise under the Medicare Act, 42 U.S.C. § 1395, et seq.

163. The Fifth Amendment to the U.S. Constitution states:

> No person shall be . . . deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

164. Article I, Section 17, of the Constitution of Michigan states, in relevant part:

> No person shall be . . . deprived of . . . property, without due process of law. The right of all individuals, firms, corporations and voluntary associations to fair and just treatment in the course of legislative and executive investigations and hearings shall not be infringed.

165. Plaintiffs had a protected property interest in reimbursement from Medicare for its home health services at the duly promulgated reimbursement rate.

166. Plaintiffs were entitled to the funds it was paid by Medicare for the

services they had rendered to Medicare beneficiaries.

167. By law, Plaintiffs were entitled to due process of law before such property could be taken from them.

168. By law, Plaintiffs were entitled to fair proceedings which met all standards of fairness and other statutory requirements for the Medicare Appeals Process, before such property could be taken from them.

169. To satisfy the requirements of due process, among other obligations:

a. TrustSolutions was required to provide Plaintiffs with the reasons for the post-payment review for the claims from 2004 to 2006, which it started after New Vision had successfully appealed the pre-payment review;

b. TrustSolutions was required to provide Plaintiffs with notice that the audit would involve statistical sampling, as well as providing them identification of the universe of claims subject to the post-payment audit;

c. TrustSolutions was required to utilize a qualified statistical expert to calculate the overpayment amount prior to issuance of the overpayment notice to the provider; and

d. TrustSolutions was required to maintain and provide to Plaintiffs the information necessary to allow New Vision to review and replicate the statistical sampling and extrapolation to be able to defend itself; and

e. TrustSolutions was required to provide Plaintiffs a meaningful opportunity to review and respond to the adverse determinations and extrapolated overpayment findings asserted against it.

170. To satisfy the requirements of due process, among other obligations:

a. NGS was required to provide to Plaintiffs the information necessary to allow them to review and replicate the statistical sampling and extrapolation;

b. NGS was required to provide Plaintiffs with a meaningful opportunity to review and respond to the adverse determinations and extrapolated overpayment findings asserted against them.

171. Both TrustSolutions and NGS failed to take any of the actions set forth in Paragraphs 169 and 170 above.

172. The most basic due process protections require that a party subject to a proceeding, such as that set forth in the Medicare Appeals Process, have access to the evidence used to support a decision adverse to it.

173. CMS requires that a PSC such as TrustSolutions maintain complete documentation of the sampling methodology followed in calculating overpayment amounts, to allow for re-creation should the methodology be challenged. (CMS, Medicare Program Integrity Manual, CMS Pub. 100-08, Ch. 8, § 8.4.4.4.) Both

TrustSolutions and NGS failed to do this.

174. By regulation, a contractor that issues a redetermination decision, such as NGS, must include "as appropriate, a summary of the clinical or scientific evidence used in making the redetermination." 42 C.F.R. § 405.956(b)(2). NGS failed to do this.

175. As found by Judge O'Leary in his Decision, Exhibit "1":

> The lack of timely responses from [TrustSolutions and NGS to Plaintiffs] guaranteed the impossibility of presenting a meaningful challenge to the validity of the statistical sampling herein by the Appellant and its statistical experts prior to reconsideration, which denied New Vision its right to a "true appeal."

(Exhibit "1," pp. 14 & 303).

176. TrustSolutions's and NGS's willful disregard of their legal obligations deprived New Vision of its ability to meaningfully challenge the validity of the statistical sampling and extrapolation and thus, deprived New Vision of a fair and impartial review at the redetermination level (Step 1 of the Medicare Appeals Process) and at the reconsideration level (Step 2 of the Medicare Appeals Process).

177. Once the reconsideration decision was rendered in late July 2010, NGS began recouping on the alleged statistically extrapolated overpayment amount of

$4,155,239.00.

178. NGS started recoupment on the statistically extrapolated overpayment amount ($4,155,239.00) without first providing New Vision with a meaningful opportunity to challenge the validity of the statistical sampling and alleged overpayment deprived New Vision of both its property interests and liberty interests without due process of law.

179. TrustSolutions and NGS had no legitimate interest in wrongfully withholding and ignoring the Plaintiffs' requests for the statistical information and other documents and information they required.

180. The actions of the Defendants stated above violated Plaintiffs' rights to both substantive and procedural due process of law.

181. Defendants' wrongful and improper actions as stated above directly caused or resulted in Plaintiffs' damages as set forth in detail in Paragraphs 115 through 122 above, incorporated herein by reference.

WHEREFORE, for the purposes of this Count, Plaintiffs request the Court enter judgment in their favor against the three (3) Defendants, jointly, severally and in individually for:

A. Pre-judgment interest on all liquidated amounts.

B. Monetary damages for all past and future losses.

C. Their attorney's fees and costs.

D. Post-judgment interest.

E. Any other relief the Court finds to be fair and equitable.

COUNT VII

DECLARATORY JUDGMENT

182. This is a cause of action for a declaratory judgment pursuant to 28 U.S.C. § 2201 and Rule 57, Federal Rules of Civil Procedure, within the jurisdiction of this Court, by the Plaintiffs against all three (3) Defendants.

183. This Count is pleaded in the alternative to and in addition to all other Counts in this Complaint.

184. Since this Count does not seek to impose civil liability on the Defendants, immunity from civil liability does not bar the Court from entering the relief sought.

185. Paragraphs 1 through 60 and 89 through 122 above are incorporated herein by reference.

186. At all times relevant hereto Defendants were acting outside the course and scope of their contracts with CMS, were not acting with due care, and were knowingly violating applicable laws and regulations.

187. Alternatively, Plaintiffs presented the claims stated in this Count to the relevant government agency and to the Defendants named herein and such claims were administratively litigated to finality as shown, in part by Exhibit "1." Plaintiffs have exhausted their administrative remedies for the claims stated in this Count.

188. Alternatively, it is alleged that the wrongful actions taken by the Defendants as stated herein and the claims made by the Plaintiffs in this Count did not arise under the Medicare Act, 42 U.S.C. § 1395, et seq.

189. Additionally, Paragraphs 143 through 155 and 163 through 178 above are incorporated herein by reference.

190. Plaintiffs request that the Court interpret the provisions of the Administrative Law Judge's Decision, Exhibit "1," and provide the Parties with a declaration as to their rights thereunder.

191. An actual justiciable controversy exists between the parties.

192. A declaratory judgment is required so as to guide the Parties in their future relationships and to preserve the Plaintiffs' legal rights.

193. A bona fide, actual, present practical need for a declaration exists.

194. The declaration requested concerns a present, ascertained or ascertainable state of facts or present controversy as to a state of facts.

195. A privilege or right of the Plaintiffs is dependent upon the facts or the

law applicable to the facts.

196. The Plaintiffs and the Defendants have an actual, present, adverse and antagonistic interest in the subject matter, both in law or in fact.

197. Declaratory relief will avoid future conflicts between the Parties in related actions.

198. The relief sought by the Plaintiffs is not merely giving of legal advice or the answer to questions propounded for curiosity.

WHEREFORE, Plaintiffs request this Court to enter a declaratory judgment declaring Plaintiffs' rights, including but not limited to the following:

A. Whether Defendants are required to comply with the Administrative Law Judge's Decision, Exhibit "1."

B. What amount is owed back to Plaintiffs by Defendants pursuant to Exhibit "1."

C. Whether or not Defendants have complied with U.S. government auditing standards in conducting their reviews of Plaintiffs.

D. Whether Defendants have complied with applicable professional standards for similar organizations in the actions they have taken with regard to the Plaintiffs.

E. Whether Plaintiffs have complied with contractual provisions

contained in their contracts (sometimes referred to as "offers for work," "work performance standards," "responses to requests for proposal," "work orders"or other similar terms).

F. Whether Defendants have complied with applicable Medicare statutes, federal regulations applicable to the Medicare Program, and Medicare guidelines, policies and manuals issued by the Medicare Program in the Defendants' activities involving these Plaintiffs.

G. Whether Defendants have exercised due care in their reviews, audits hearings, appeals and other actions taken in relation to these Plaintiffs.

COUNT VIII

INJUNCTION

199. This is a cause of action for injunctive relief pursuant to Rule 65, Federal Rules of Civil Procedure, within the jurisdiction of this Court, by the Plaintiffs against all three (3) Defendants.

200. This Count is pleaded in the alternative to and in addition to all other Counts in this Complaint.

201. Since this Count does not seek to impose civil liability on the Defendants, immunity from civil liability does not bar the Court from entering the relief sought.

202. Paragraphs 1 through 60, and 89 through 122 above are incorporated herein by reference.

203. At all times relevant hereto Defendants were acting outside the course and scope of their contracts with CMS, were not acting with due care, and were knowingly violating applicable laws and regulations.

204. Alternatively, Plaintiffs presented the claims stated in this Count to the relevant government agency and to the Defendants named herein and such claims were administratively litigated to finality as shown, in part by Exhibit "1." Plaintiffs have exhausted their administrative remedies for the claims stated in this Count.

205. Alternatively, it is alleged that the wrongful actions taken by the Defendants as stated herein and the claims made by the Plaintiffs in this Count did not arise under the Medicare Act, 42 U.S.C. § 1395, et seq.

206. For purposes of this Count, regardless of any other allegations, Plaintiffs plead that they have no adequate remedy at law.

207. Additionally, Paragraphs 143 through 155 and 163 through 178 above are incorporated herein by reference.

208. Without and injunction, Defendants will continue their injurious acts, continue to interfere in the business relationships of the Plaintiffs, and continue to damage the professional reputations of the Plaintiffs.

209. Plaintiffs have a substantial likelihood of success on the merits.

210. Plaintiffs will suffer irreparable harm from the acts of the Defendants unless injunctive relief is granted. Such harm is real and imminent.

211. The harm the Plaintiffs will suffer outweighs any harm the Defendants will suffer if an injunction is entered.

212. An injunction will serve the public interest.

213. The interests of third persons and of the public will be served by the entry of a permanent injunction.

214. An injunction can be practically and adequately framed and enforced.

215. Justice requires the Court to enter an injunction.

WHEREFORE, Plaintiff requests the Court enter an injunction against the three (3) Defendants, ordering them each:

A. To comply in all respects with the Administrative Law Judge's Decision, Exhibit "1."

B. Remove the Plaintiffs from any ongoing prepayment reviews.

C. Terminate any ongoing audits, reviews or investigations they are

conducting of the Plaintiffs for any Medicare claims submitted at any time prior to 2013.

D. Comply in the future with all applicable Medicare Program laws, regulations, and guidance and contracts they have with CMS, with respect to these Plaintiffs.

JURY DEMAND

216. Plaintiffs demand a trial by jury for all issues so triable.

REQUEST FOR RELIEF

WHEREFORE, Plaintiffs respectfully requests that this Court grant the following relief against Defendants, jointly, severally and individually, as follows:

A. A ruling that Anthem unlawfully used TrustSolutions and NGS as mere instrumentalities and as its alter egos, and piercing the corporate/company veils of TrustSolutions and NGS;

B. Issuance of a writ of mandamus to enforce the ALJ Decision, Exhibit "1," as requested in Counts I and II;

C. Monetary damages, both general and special;

D. Pre-judgment interest on all liquidated damages;

E. A Declaratory Judgment as requested in Count VII;

F. An injunction as requested in Count VIII;

G. Attorney's fees and costs;

H. Post-judgment interest; and

I. All other relief to which Plaintiffs are entitled at law or equity.

CERTIFICATE OF SERVICE

I hereby certify that I filed the foregoing electronically via the Clerk of Court's CM/ECF system, which automatically serves a copy on all parties who have appeared; that I have also mailed a copy via U.S. mail, postage prepaid, to the following non-CM/ECF Defendants:

Service List:

TrustSolutions, LLC, via its
Registered Agent: CT Corp System
8020 Excelsior Drive, Ste. 200
Madison, WI 53717

Anthem, Inc., via its
Registered Agent: Kathleen S. Kiefer
120 Monument Circle
Indianapolis, IN 46204

National Government Services, Inc., via its Registered Agent: CT Corp System
150 West Market Street
Indianapolis, IN 46204

Additionally, I certify that I have served a copy of this Second Amended Complaint on each of the foregoing via U.S. certified mail, return receipt requested, postage pre-paid. I further certify that I have served a copy of the foregoing via e-mail on the following CM/ECF participant who has filed an appearance on behalf of Defendants Anthem, Inc., TrustSolutions, LLC, and National Government Services, Inc.:

BARBARA L. McQUADE
United States Attorney
Zak Toomey (MO61618)
Assistant U.S. Attorney
211 W. Fort Street, Suite 2001
Detroit, Michigan 48226
Phone: (313) 226-9617
E-mail: Zak.toomey@usdoj.gov

this 11th day of March 2017.

/s/ George F. Indest III

GEORGE F. INDEST III, J.D., M.P.A., LL.M.
Board Certified in Health Law by The Florida Bar
Florida Bar No. 382426
CAROLE C. SCHRIEFER, R.N., J.D.
Florida Bar No. 835293
THE HEALTH LAW FIRM
Attorney for Plaintiffs
1101 Douglas Avenue
Altamonte Springs, Florida 32714
Phone: (407) 331-6620
Fax: (407) 331-3030

E-mail: GIndest@TheHealthLawFirm.com
Secondary e-mail: CourtFilings@TheHealthLawFirm.com
ATTORNEYS FOR PLAINTIFFS NEW VISION HOME HEALTH CARE, INC., AND SALEEM SHAKOOR

Exhibit "1" Administrative Law Judge James S. O'Leary's Decision of Sept. 4, 2013, HHS OMHA ALJ Case No. 1-909525621 (redacted)

GFI/sg
S:\2200-2299\2208\001\410-Pleadings-Draft & Final\Second Am Complaint--rev 37.wpd