IN THE CIRCUIT COURT OF FAULKNER COUNTY, ARKANSAS
_____ DIVISION

STATE OF ARKANSAS **PLAINTIFF**

VS. **NO. _____**

DR. CHARLES TODD, JR.; **DEFENDANTS**
KAREN TODD;
CHARLES TODD, P.A. d/b/a
TODD EYE CLINIC (aka PARK TODD EYE CLINIC); and
CONWAY EYE CARE, PLC

COMPLAINT

Comes now the Plaintiff, the State of Arkansas (hereinafter "State"), by and through Attorney General Leslie Rutledge and Assistant Attorney General Valerie Kelly, and for its complaint against Dr. Charles Todd, Jr. (hereinafter "Charles Todd"), Karen Todd, Charles Todd, P.A. d/b/a Todd Eye Clinic (aka Park Todd Eye Clinic) (hereinafter "Todd Eye Clinic"), and Conway Eye Care, PLC (hereinafter "Conway Eye Care") states:

INTRODUCTION

1. This matter is a civil action regarding statutory violations, civil penalties, and damages owed by Defendants Charles Todd, Karen Todd, Todd Eye Clinic and Conway Eye Care as a result of breach of contract and false claims and fraudulent billings submitted to the Arkansas Medicaid Program in connection with the sale of optometric services to vulnerable consumers.

2. The State has filed this matter to seek damages, restitution, and civil penalties against Defendants pursuant to the Arkansas Medicaid Fraud False Claims Act codified at Ark. Code Ann. §§ 20-77-901 to -912, the Arkansas Deceptive Trade Practices Act codified at Ark. Code Ann. §§ 4-88-101 to -117 and Arkansas contract law.

PARTIES

3. Leslie Rutledge is the duly-elected Attorney General of the State of Arkansas. The Attorney General is authorized to bring a civil action for violations of the Medicaid Fraud False Claims Act pursuant to Arkansas Code Annotated § 20-77-902 and for civil enforcement of the Deceptive Trade Practices Act pursuant to Arkansas Code Annotated § 4-88-104. The Medicaid Fraud Control Unit (hereinafter "MFCU") is a division of the Arkansas Attorney General's office which is charged with investigation and prosecution of all fraud against the Medicaid Program, including criminal actions of Medicaid Fraud and civil actions involving Medicaid Fraud False Claims. The Attorney General's Office is located at 323 Center Street, Suite 200, Little Rock, Pulaski County, Arkansas 72201.

4. Defendant Dr. Charles Todd, Jr., is an individual residing at 3030 Dallas Loop, Conway, Faulkner County, AR 72034. At all times material to this action, Charles Todd was an optometrist licensed by the Arkansas State Board of Optometry to provide optometric services to Arkansas residents.

5. Defendant Karen Todd, is an individual residing at 3030 Dallas Loop, Conway, Faulkner County, AR 72034. At all times material to this action, Karen Todd was married to Charles Todd and served as an office manager at Todd Eye Clinic.

6. Defendant Charles Todd, P.A. d/b/a Todd Eye Clinic (aka Park Todd Eye Clinic) is a domestic for-profit professional corporation authorized to do business in the State of Arkansas. Defendant Todd Eye Clinic is a provider of optometric services. The registered agent for service of process for Todd Eye Clinic is Karen Todd. Todd Eye Clinic's principle place of business during the relevant time for this matter was located at 552 Locust Avenue, Conway, AR 72034.

7. Defendant Conway Eye Care, PLC, is a domestic for-profit limited liability company authorized to do business in the State of Arkansas. Conway Eye Care is a provider of optometric services. The registered agent for service of process for Conway Eye Care is Charles Todd. Conway Eye Care's principle place of business during the relevant time for this matter was located at 552 Locust Avenue, Conway, AR 72034.

8. The Arkansas Medical Assistance Program (hereinafter "Medicaid") is a joint federal-state funded program under Title XIX of the Social Security Act. Medicaid is a program that helps pay for medically necessary services for needy and low-income persons. The Arkansas Department of Human Services (hereinafter "DHS") administers the Medicaid Program in Arkansas.

JURISDICTION AND VENUE

9. This Court has subject matter jurisdiction over this matter under Ark. Code Ann. §§ 16-13-201, 20-77-908(a), 4-8-104 and 4-8-112(b).

10. Venue is proper in Faulkner County, Arkansas, pursuant to Ark. Code Ann. §§ 20-77-908(a) and 4-8-112(a).

FACTUAL ALLEGATIONS

11. Charles Todd is an optometrist licensed in Arkansas. At all times relevant to this action, Charles Todd owned, operated, and/or directly controlled Todd Eye Clinic and Conway Eye Care. Charles Todd was responsible for providing optometric services through Todd Eye Clinic and Conway Eye Care. As office manager, Karen Todd was directly responsible for all aspects of the daily operations of Todd Eye Clinic and Conway Eye Care, including submission of claims to the Medicaid Program. Charles Todd and Karen Todd had direct knowledge of the requirements imposed by the Medicaid Program.

12. On or about October 15, 1998, Charles Todd entered into a contract with DHS (hereinafter "Todd Eye Clinic Medicaid Contract") allowing him to participate in the Medicaid Program to provide optometrist/optician services as Todd Eye Clinic. A true and correct copy of the Todd Eye Clinic Medicaid Contract is attached hereto as Exhibit A. At all times relevant to this action, Todd Eye Clinic was certified to provide optometric service through Medicaid and held a Medicaid Provider Number (134909722).

13. On or about February 26, 1999, Charles Todd entered into a contract with DHS (hereinafter "Conway Eye Care Medicaid Contract") allowing him to participate in the Medicaid Program to provide optometrist/optician services as Conway Eye Care. A true and correct copy of the Conway Eye Care Medicaid Contract is attached hereto as Exhibit B. At all times relevant to this action, Conway Eye Care was certified to provide optometric service through Medicaid and held a Medicaid Provider Number (135733722).

14. By entering into these provider agreements, Defendants became Medicaid Providers and were able to provide treatment to Arkansas residents that were covered by the Medicaid Program.

15. Pursuant to paragraph 1(D) of the Medicaid Contracts (Exs. A and B), Defendants promised to bill Medicaid only after a service had been provided.

16. Pursuant to paragraph 1(J) of the Medicaid Contracts (Exs. A and B), Defendants, by participating in the Arkansas Medicaid Program, agreed that they had been furnished with a copy of the Arkansas Medicaid Provider Manual containing the rules, regulations, and procedures pertaining to the optometric services and acknowledged that the terms and conditions of the Arkansas Medicaid Provider Manual were incorporated into the terms of the contracts.

17. Pursuant to paragraph 1(K) of the Medicaid Contracts (Exs. A and B), Defendants acknowledged that they would conform to all Medicaid requirements covered in Federal or State laws, regulations, or manuals.

18. Defendants acknowledged that by endorsing or depositing checks from the Medicaid Program any falsification or concealment of a material fact may subject him to prosecution under State law. Attached hereto as Exhibit C is a true and correct copy of the Todd Eye Clinic acknowledgement. Attached hereto as Exhibit D is a true and correct copy of the Conway Eye Care acknowledgement.

19. Between March 5, 2013, and September 30, 2019, Defendants routinely billed the Medicaid Program for optometric services and received $815,085.59 from 744 claims filed with the Arkansas Medicaid Program.

20. On September 19, 2019, the MFCU received a fraud complaint alleging that Karen Todd had committed Medicaid fraud.

21. After receiving the complaint, MFCU staff reviewed the billing data from Todd Eye Clinic and Conway Eye Care. The data revealed that the Charles Todd had the highest Medicaid crossover paid amounts in the State of Arkansas compared to other optometrist providers for the years 2015 to 2019. Crossover claims occur when a biller is required to bill both Medicare and Medicaid because the recipient of services is a "dual eligible," *i.e.*, they have both types of insurance. Claims for dual eligible recipients are required to be submitted to Medicare first. After Medicare evaluates and pays the claim, the claim is sent to Medicaid (crossed over) to pay only the coinsurance and any unpaid deductible the recipient still has for the year.

22. On October 3, 2019, Karen Todd was interviewed by MFCU staff after being read the *Miranda* rights. Karen Todd admitted entering false information in the Medicare/Medicaid

crossover claims portal. She reported that the Medicaid crossover portal site allowed her to input any number she chose, and the filters failed to detect the overage requests. Karen Todd was aware that she was entering fraudulent amounts and that Charles Todd, Todd Eye Clinic and Conway Eye Care were being overpaid.

23. Charles Todd knew, reasonably should have known or acted in reckless disregard to the fact that he, Todd Eye Clinic and Conway Eye Care were being overpaid based on the fraudulent amounts entered into the Medicare/Medicaid crossover claims portal by Karen Todd.

24. The MFCU found that there were 722 claims involving crossover claims and that Medicaid paid $814,166.88 to the Defendants for the fraudulent claims.

25. The MFCU investigation also found fraudulent billings associated with direct claims billed to Medicaid. Direct claims are claims other than crossover claims that in this case were double billed to both Medicare and Medicaid.

26. The MFCU found that there were 22 direct claims that were double billed to both Medicare and Medicaid and that Medicaid paid $918.71 to the Defendants for the fraudulent claims.

27. The MFCU investigated and reviewed all Medicaid claims submitted by Defendants and all claims paid by Medicaid to Defendant, bank statements, documentation maintained by Defendant, and documentation maintained by other entities pertaining to services by Defendants for the time period of March 5, 2013 through September 30, 2019.

28. The MFCU determined that Defendants purposely made false statements or false representations of material facts in claims for payment and for use in determining rights to a benefit or payment under the Arkansas Medicaid Program between March 5, 2013, and September 9,

2019, in violation of the Arkansas Medicaid rules and regulations and the Todd Eye Clinic and Conway Eye Care Medicaid Contracts.

29. Of the $815,085.59 false and fraudulent crossover and double-billed direct claims submitted by Defendants and all claims paid by Medicaid, 457 claims totaling $643,390.64 were submitted between September 1, 2016, and September 9, 2019, while the remaining 287 claims totaling $171,694.95 were submitted between March 5, 2013, and August 31, 2016.

30. As set forth herein, Defendants committed positive acts of fraud, which they concealed and which could not have been detected by Plaintiff exercising reasonable diligence until, at the earliest, the receipt of the fraud complaint by the MFCU on September 19, 2019. Accordingly, Plaintiff avers that Defendants should be estopped from asserting the statute of limitations as to the claims herein and that any applicable statute of limitations be tolled and not begin to run until September 19, 2019, due to Defendants' fraudulent concealment.

31. On October 17, 2019, Karen Todd was arrested on one count of Class A felony Medicaid Fraud in accordance with Ark. Code Ann. § 5-55-103.

COUNT ONE:
THE ARKANSAS MEDICAID FRAUD FALSE CLAIMS ACT

32. The State of Arkansas re-alleges and incorporates the foregoing paragraphs as if fully set forth herein.

33. Defendants knowingly made false statements or representations of material fact in numerous applications for payment under the Arkansas Medicaid Program between March 5, 2013, through September 30, 2019, which are violations of Ark. Code Ann. § 20-77-902.

34. In submitting the false claims to the Arkansas Medicaid Program as set forth herein, Karen Todd acted as the authorized agent and employee and on behalf of her principals Charles

Todd, Todd Eye Clinic and Conway Eye Care, who are vicariously liable for the acts and misrepresentations of Karen Todd.

35. Defendants collected reimbursement for claims submitted to the Medicaid Program for services allegedly provided through the Arkansas Medicaid Optometric (Visual) Program, knowing that these claims were false in that Defendants:

(a) For many of the crossover billings, failed to submit the bill to Medicare first; or

(b) For other crossover billings, falsified the data by moving decimals, inflating numbers, keying in random figures, or double billing with the knowledge that whatever was submitted through the Medicaid portal, would be paid by Medicaid; or

(c) For direct claims, double billed to both Medicare and Medicaid.

36. As a direct and proximate result of Defendants' submission of false claims, the State incurred damages by paying funds to Defendants. The State asserts a claim for judgment against Defendants, jointly and severally, for restitution of $815,085.59 to the Medicaid Program and civil penalties pursuant to Ark. Code Ann. § 20-77-903 in an amount to be determined at the trial of this matter.

COUNT TWO:
BREACH OF CONTRACT

37. The State of Arkansas re-alleges and incorporates the foregoing paragraphs as if fully set forth herein.

38. Defendants Charles Todd, Todd Eye Clinic and Conway Eye Care entered into Medicaid Contracts with the State (Exs. A and B). Under the terms of the Medicaid Contracts, Defendants were charged with knowledge pertaining to, and had a duty to abide by, all applicable statutes, rules, regulations, and manuals concerning the Arkansas Medicaid Optometric (Visual) Program.

39. Specifically, Defendants agreed pursuant to paragraph (1)(D) of the Medicaid Contracts "[t]o bill Medicaid only after a service has been provided, or as otherwise specified in the appropriate Arkansas Medicaid Provider Manual, Official Notice, or Remittance Advice message."

40. Further, Defendants agreed pursuant to Paragraph (1)(K) of the Medicaid Contracts "[t]o conform to all Medicaid requirements covered in Federal or State laws, regulations or manuals."

41. As set forth in the previous paragraphs, Defendants ignored the relevant statutes, rules, regulations, and manuals when they submitted false and/or fraudulent claims, in violation of the governing law.

42. Due to Defendants' conduct in breach of the contractual obligations, the State of Arkansas incurred damages in the amount of $815,085.59, and is entitled to recover those damages and any other relief this Court deems appropriate.

COUNT THREE:
THE ARKANSAS DECEPTIVE TRADE PRACTICES ACT

43. The State of Arkansas re-alleges and incorporates the foregoing paragraphs as if fully set forth herein.

44. The Arkansas Deceptive Trade Practices Act codified at Ark. Code Ann. §§ 4-88-101 to -117 sets forth the State's statutory program prohibiting deceptive and unconscionable trade practices. The business practices of Defendants constitute business, commerce or trade and the sale of services under the Act.

45. Defendants knowingly made false representations as to the characteristics, uses, benefits, source, approval or certification of services; acted, used or employed deception, fraud or false pretense; concealed, suppressed or omitted material facts with intent that others rely upon the

concealment, suppression or omission; and otherwise engaged in unconscionable, false or deceptive acts or practices in business commerce or trade in submitting numerous applications for payment under the Arkansas Medicaid Program between March 5, 2013, through September 30, 2019, in violation of Ark. Code Ann. §§ 4-88-107 and -108.

46. Pursuant to Ark. Code Ann. § 4-88-113(d)(1), Charles Todd, Todd Eye Clinic and Conway Eye Care are jointly and severally liable for Karen Todd's violations of the Arkansas Deceptive Trade Practices Act.

47. Defendants have engaged in conduct prohibited by the Arkansas Deceptive Trade Practices Act by submitting claims and collecting reimbursement for claims submitted to the Medicaid Program for services allegedly provided through the Arkansas Medicaid Optometric (Visual) Program, knowing that these claims were false in that Defendants:

(a) For many of the crossover billings, failed to submit the bill to Medicare first; or

(b) For other crossover billings, falsified the data by moving decimals, inflating numbers, keying in random figures, or double billing with the knowledge that whatever was submitted through the Medicaid portal, would be paid by Medicaid; or

(c) For direct claims, double billed to both Medicare and Medicaid.

48. As a direct and proximate result of Defendants' submission of false claims, the State incurred damages by paying funds to Defendants. The State asserts a claim for judgment against Defendants, jointly and severally, for restitution of $815,085.59 to the Medicaid Program and civil penalties pursuant to Ark. Code Ann. § 4-88-113 in an amount to be determined at the trial of this matter.

49. The State will exercise its right to a trial by jury.

PRAYER FOR RELIEF

WHEREFORE, the State of Arkansas prays for a judgment in its favor and against Defendants as follows:

(a) restitution to the Arkansas Medicaid Program;

(b) civil penalties as outlined in Ark. Code Ann. § 20-77-903 and/or § 4-88-113;

(c) an award of all expenses reasonably incurred in the investigation and litigation, including but not limited to expenses for expert witnesses, attorneys' fees and court costs; and

(d) For all other relief to which it may be entitled.

Respectfully submitted,

LESLIE RUTLEDGE
ARKANSAS ATTORNEY GENERAL

By: Valerie K. Kelly
Valerie Kelly, #94170
Assistant Attorney General
323 Center Street, Suite 200
Little Rock, AR 72201
(501) 682- 7760 (T)
(501) 682-8135 (F)
Valerie.Kelly@arkansasag.gov

By: Chris Holleman
Chris Holleman, #2021102
Assistant Attorney General
323 Center Street, Suite 200
Little Rock, AR 72201
(501) 682- 7760 (T)
(501) 682-8135 (F)
Chris.Holleman@arkansasag.gov

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STATE OF ARKANSAS **PLAINTIFF**

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KAREN TODD;
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TODD EYE CLINIC (aka PARK TODD EYE CLINIC); and
CONWAY EYE CARE, PLC

EXHIBITS

CONTRACT
TO PARTICIPATE IN THE ARKANSAS MEDICAL ASSISTANCE PROGRAM
ADMINISTERED BY THE DEPARTMENT OF HUMAN SERVICES
TITLE XIX (MEDICAID)

e following agreement is entered into between Charles L. Todd, Jr, O.D. hereinafter called Provider, and the Department of Human Services, hereafter called Department:

1. Provider, in consideration of the material benefits to be derived, and the covenants and undertakings of the Department agrees to the following:

   A. To keep all records, as set forth in the appropriate Arkansas Medicaid Provider Manual, Official Notice and Remittance Advice Message, to fully disclose the extent of services provided to individuals receiving assistance under the State Plan.

   B. To make available all records herein specified to satisfy audit requirements under the Program, to furnish all such records for audits conducted periodically by the Department, the Medicaid Fraud Division of the Attorney General, or their designated agents, and/or representatives. For all Medicaid recipients these records include, but are not limited to those records which are defined in Section "A" of this contract. For patients who are not Medicaid recipients, the only records which must be furnished are financial records of charges billed to private patients to ensure that charges billed to Medicaid do not exceed charges billed to private patients.

   C. To accept Medicare assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any appropriate deductible, or coinsurance which may be due and payable under Title XIX (Medicaid).

   D. To bill Medicaid only after a service has been provided, or as otherwise specified in the appropriate Arkansas Medicaid Provider Manual, Official Notice, Remittance Advice Message.

   E. To accept payment from Medicaid as payment in full for a covered service, and to make no additional charges to the patient or accept any additional payment from the patient for that service which is covered under the Medicaid Program.

   F. To take assignment and file claims with third party sources (medical, liability insurance, etc.), and if third party payment is made to the Provider, to reimburse Medicaid up to the amount Medicaid paid for the services; to make no claims against third party sources for services for which a claim has been submitted to Medicaid; and to notify Medicaid of the identity of each third party sources discovered after submission of a claim or claims to Medicaid.

   G. To make no charge to a patient for a claim or a portion of a claim when a determination that the service was not medically necessary is made based on the professional opinion of appropriate and qualified medical persons on a committee which performs peer review of Medicaid cases either for the Division of Medical Services or for Peer Review Organizations (PRO); except that such charge can be made to the patient when he/she has requested the service and has prior knowledge that he/she will be responsible for the cost of such service; and to reimburse the Division of Medical Services for all monies paid for claims for services that later were determined to be "not medically necessary".

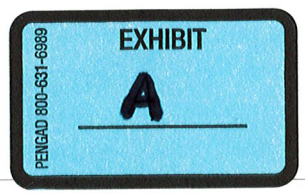
   H. To provide all services without discrimination on the grounds of race, color, national origin, or physical or mental disability within the provisions of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

   I. To accept all changes legally made in the Program, and recognize and abide by such changes upon being notified by the Medicaid Program in the form of an update to, or an Official Notice/Remittance Advice Message pertaining to, the appropriate Arkansas Medicaid Provider Manual.

   J. That the Department has furnished the Provider with a copy of the Arkansas Medicaid Provider Manual containing the rules, regulations and procedures pertaining to his/her profession. The Provider agrees that the terms and conditions contained therein shall be a part of this contract if the same were set out verbatim herein. The Provider states that he/she is currently licensed to practice in Arkansas or within the State where services were rendered and agrees to promptly notify the Department if his/her license is revoked or suspended. The Provider acknowledges by signature on this contract that he/she has received a copy of the appropriate Arkansas Medicaid Provider Manual.

   K. To conform to all Medicaid requirements covered in Federal or State laws, regulations or manuals.

   L. To certify by original signature within 48 hours of claims being submitted by an electronic media, a claim count and dollar amount billed, that the information on the claims submitted is true, accurate and complete. The Provider agrees to maintain this as a matter of record for all claims submitted electronically, by any media.



M. To notify the Department prior to any change of ownership or operating status. Upon change of ownership or operating status the successor owner or operator shall, as a condition of assumption of this agreement, hold the Department harmless for any rate or payment increases, decreases, or adjustments without respect to whether the increase, decrease, or adjustment relates to services delivered prior to the change in ownership or operating status.

N. FOR HOSPITALS ONLY
To understand that the Peer Review Organization (Arkansas Foundation for Medical Care, Inc.) is responsible for the review of Medicaid admissions to inpatient hospital facilities, specifically for length of stay purposes, medical necessity and as otherwise specified in the Memorandum of Understanding between the individual hospital and Arkansas Foundation for Medical Care, Inc.

II. The Department, in consideration of the material benefits and the covenants and undertakings of the Provider, agrees as follows:

A. To make payment to the above named Provider for the appropriate Medicaid Services provided to eligible Medicaid recipients in accordance with the current Medicaid pricing index in effect at the time of billing, and in accordance with the manual of rules, regulations and procedures that is a part of this contract.

B. To notify the above named Provider of appropriate changes in Medicaid rules and regulations as they occur.

C. To safeguard the confidentiality of any Medicaid record(s) received by the Department, or its fiscal intermediary as specified in Federal and State regulations.

III. This contract may be terminated or renewed in accordance with the following provisions:

A. This contract may be voluntarily terminated by either party by giving thirty (30) days written notice to the other party;

B. This contract will be automatically renewed for one year on July 1 of each year if neither party gives notice requesting termination;

C. This contract may be terminated immediately by the Department for the following reasons:
1) Sanction of provider
2) Returned mail
3) Death of provider
4) Change of ownership
5) Other reasons set out in the appropriate Arkansas Medicaid Provider Manual, Official Notice/Remittance Advice Message.
6) Failure to conform to the terms or requirements of this contract.

If the Provider is a legal entity other than a person, the person signing this Provider Contract on behalf of the Provider warrants that he/she has legal authority to bind the Provider. The signature of the Provider or the person with the legal authority to bind the Provider on this contract certifies the Provider understands that payment and satisfaction of these claims will be made from the Federal and State funds, and that any false claims, statements, or documents, or concealment of material fact, may be prosecuted under applicable Federal and State laws.

PROVIDER	DEPARTMENT OF HUMAN SERVICES
By: _____ (Signature)	By: Glenda Matchett (Signature)
Name: Charles L. Todd, Jr. OD (Typed Name)	Name: _____ (Typed Name)
Title: Optometrist	Title: _____
Date: 8-19-98	Date: 10-15-98 (Effective Date of Contract)

RECEIVED
OCT - 9 1998
DMS / MED ASST

DMS-653 (R. 6/95)

CONTRACT
TO PARTICIPATE IN THE ARKANSAS MEDICAL ASSISTANCE PROGRAM
ADMINISTERED BY THE DEPARTMENT OF HUMAN SERVICES
TITLE XIX (MEDICAID)

e following agreement is entered into between Conway Eye Care, hereinafter called Provider, and the Department of Human Services, hereafter called Department:

1. Provider, in consideration of the material benefits to be derived, and the covenants and undertakings of the Department agrees to the following:

   A. To keep all records, as set forth in the appropriate Arkansas Medicaid Provider Manual, Official Notice and Remittance Advice Message, to fully disclose the extent of services provided to individuals receiving assistance under the State Plan.

   B. To make available all records herein specified to satisfy audit requirements under the Program, to furnish all such records for audits conducted periodically by the Department, the Medicaid Fraud Division of the Attorney General, or their designated agents, and/or representatives. For all Medicaid recipients these records include, but are not limited to those records which are defined in Section "A" of this contract. For patients who are not Medicaid recipients, the only records which must be furnished are financial records of charges billed to private patients to ensure that charges billed to Medicaid do not exceed charges billed to private patients.

   C. To accept Medicare assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any appropriate deductible, or coinsurance which may be due and payable under Title XIX (Medicaid).

   D. To bill Medicaid only after a service has been provided, or as otherwise specified in the appropriate Arkansas Medicaid Provider Manual, Official Notice, Remittance Advice Message.

   E. To accept payment from Medicaid as payment in full for a covered service, and to make no additional charges to the patient or accept any additional payment from the patient for that service which is covered under the Medicaid Program.

   F. To take assignment and file claims with third party sources (medical, liability insurance, etc.), and if third party payment is made to the Provider, to reimburse Medicaid up to the amount Medicaid paid for the services; to make no claims against third party sources for services for which a claim has been submitted to Medicaid; and to notify Medicaid of the identity of each third party sources discovered after submission of a claim or claims to Medicaid.

   G. To make no charge to a patient for a claim or a portion of a claim when a determination that the service was not medically necessary is made based on the professional opinion of appropriate and qualified medical persons on a committee which performs peer review of Medicaid cases either for the Division of Medical Services or for Peer Review Organizations (PRO); except that such charge can be made to the patient when he/she has requested the service and has prior knowledge that he/she will be responsible for the cost of such service; and to reimburse the Division of Medical Services for all monies paid for claims for services that later were determined to be "not medically necessary".

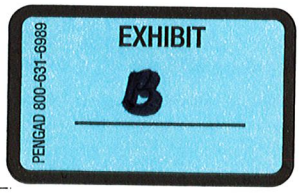
   H. To provide all services without discrimination on the grounds of race, color, national origin, or physical or mental disability within the provisions of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

   I. To accept all changes legally made in the Program, and recognize and abide by such changes upon being notified by the Medicaid Program in the form of an update to, or an Official Notice/Remittance Advice Message pertaining to, the appropriate Arkansas Medicaid Provider Manual.

   J. That the Department has furnished the Provider with a copy of the Arkansas Medicaid Provider Manual containing the rules, regulations and procedures pertaining to his/her profession. The Provider agrees that the terms and conditions contained therein shall be a part of this contract if the same were set out verbatim herein. The Provider states that he/she is currently licensed to practice in Arkansas or within the State where services were rendered and agrees to promptly notify the Department if his/her license is revoked or suspended. The Provider acknowledges by signature on this contract that he/she has received a copy of the appropriate Arkansas Medicaid Provider Manual.

   K. To conform to all Medicaid requirements covered in Federal or State laws, regulations or manuals.

   L. To certify by original signature within 48 hours of claims being submitted by an electronic media, a claim count and dollar amount billed, that the information on the claims submitted is true, accurate and complete. The Provider agrees to maintain this as a matter of record for all claims submitted electronically, by any media.



M. To notify the Department prior to any change of ownership or operating status. Upon change of ownership or operating status the successor owner or operator shall, as a condition of assumption of this agreement, hold the Department harmless for any rate or payment increases, decreases, or adjustments without respect to whether the increase, decrease, or adjustment relates to services delivered prior to the change in ownership or operating status.

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To understand that the Peer Review Organization (Arkansas Foundation for Medical Care, Inc.) is responsible for the review of Medicaid admissions to inpatient hospital facilities, specifically for length of stay purposes, medical necessity and as otherwise specified in the Memorandum of Understanding between the individual hospital and Arkansas Foundation for Medical Care, Inc.

II. The Department, in consideration of the material benefits and the covenants and undertakings of the Provider, agrees as follows:

A. To make payment to the above named Provider for the appropriate Medicaid Services provided to eligible Medicaid recipients in accordance with the current Medicaid pricing index in effect at the time of billing, and in accordance with the manual of rules, regulations and procedures that is a part of this contract.

B. To notify the above named Provider of appropriate changes in Medicaid rules and regulations as they occur.

C. To safeguard the confidentiality of any Medicaid record(s) received by the Department, or its fiscal intermediary as specified in Federal and State regulations.

III. This contract may be terminated or renewed in accordance with the following provisions:

A. This contract may be voluntarily terminated by either party by giving thirty (30) days written notice to the other party;

B. This contract will be automatically renewed for one year on July 1 of each year if neither party gives notice requesting termination;

C. This contract may be terminated immediately by the Department for the following reasons:
1) Sanction of provider
2) Returned mail
3) Death of provider
4) Change of ownership
5) Other reasons set out in the appropriate Arkansas Medicaid Provider Manual, Official Notice/Remittance Advice Message.
6) Failure to conform to the terms or requirements of this contract.

If the Provider is a legal entity other than a person, the person signing this Provider Contract on behalf of the Provider warrants that he/she has legal authority to bind the Provider. The signature of the Provider or the person with the legal authority to bind the Provider on this contract certifies the Provider understands that payment and satisfaction of these claims will be made from the Federal and State funds, and that any false claims, statements, or documents, or concealment of material fact, may be prosecuted under applicable Federal and State laws.

PROVIDER

By: _____ (Signature)

Name: Charles Todd, Jr. Conway Eye Care (Typed Name)

Title: Optometrist

Date: 1-5-99

DEPARTMENT OF HUMAN SERVICES

By: Glenda Mabrey (Signature)

Name: _____ (Typed Name)

Title: _____

Date: 2-20-99 (Effective Date of Contract)

DMS-653 (R. 6/95)

RECEIVED

FEB 12 1999

DMS / MED ASST

Authorization for Automatic Deposit

Name of Medicaid Provider Charles L Todd Jr.

Provider ID # 134909722 Taxonomy Code

Provider Address 652 Locust St. Telephone Number 5013296859

City, State Conway AR Zip Code 72034

Type of Authorization ☒ New ☐ Change ☐ Cancel

☒ Checking ☐ Savings **(if not indicated will be automatically entered as checking)**

ABA Transit Number Bank Account Number 01002 7009

A COPY OF A VOIDED CHECK OR A LETTER FROM THE BANK IS REQUIRED TO VERIFY THESE NUMBERS. THE NAME ON THE VOIDED CHECK OR LETTER FROM BANK MUST MATCH THE NAME OF THE MEDICAID PROVIDER STATED ABOVE. TEMPORARY CHECKS ARE INVALID IF THEY DO NOT HAVE THE PROVIDER'S NAME AND ADDRESS PRINTED BY THE BANK.

Name of Bank 1st Security Bank

Bank Address Front St.

City, State Conway AR Zip Code 72034

I hereby authorize the Arkansas Medicaid Program/Title XIX, to initiate credit entries to my bank account as indicated above and the depository named above to credit the same to such account. I understand I am responsible for the validity on this form.

I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws.

X _____
Provider's Original Signature (required)

Please return this form to:
Medicaid Provider Enrollment Unit
HP Enterprise Services
P.O. Box 8105
Little Rock, AR 72203-8105

JAN 13 REC'D

EXHIBIT C

PENGAD 800-631-6989

Reviewed 1-13-11 RB

(Rev. 10/15/08)

Authorization for Automatic Deposit

Name of Medicaid Provider Conway Eye Care

Provider ID # 135733722 Taxonomy Code _____

Provider Address 552 Locust St. Telephone Number 501 3296859

City, State Conway AR Zip Code 72034

Type of Authorization ☒ New ☐ Change ☐ Cancel

☒ Checking ☐ Savings **(if not indicated will be automatically entered as checking)**

ABA Transit Number _____ Bank Account Number 0100270009

A COPY OF A VOIDED CHECK OR A LETTER FROM THE BANK IS REQUIRED TO VERIFY THESE NUMBERS. THE NAME ON THE VOIDED CHECK OR LETTER FROM BANK MUST MATCH THE NAME OF THE MEDICAID PROVIDER STATED ABOVE. TEMPORARY CHECKS ARE INVALID IF THEY DO NOT HAVE THE PROVIDER'S NAME AND ADDRESS PRINTED BY THE BANK.

Name of Bank 1st Security Bank

Bank Address Front Street

City, State Conway AR Zip Code 72034

I hereby authorize the Arkansas Medicaid Program/Title XIX, to initiate credit entries to my bank account as indicated above and the depository named above to credit the same to such account. I understand I am responsible for the validity on this form.

I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws.

X _____
Provider's Original Signature (required)

Please return this form to:
Medicaid Provider Enrollment Unit
HP Enterprise Services
P.O. Box 8105
Little Rock, AR 72203-8105

(Rev. 10/15/08)