IN THE MATTER OF	*	BEFORE THE MARYLAND STATE
KELECHI MEZU NNABUE, O.D.	*	**BOARD OF EXAMINERS**
Respondent	*	**IN OPTOMETRY**
License Number: TA1714	*	**Case Number: TA 2021-011**

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CONSENT ORDER

The Maryland State Board of Examiners in Optometry (the "Board") issued charges against **KELECHI MEZU NNABUE, O.D.** (the "Respondent"), License Number **TA1714**, on February 7, 2022. The Respondent was charged with violating the Maryland Optometry Act (the "Act") codified at Md. Code Ann., Health Occ. §§ 11-101 *et seq.* (2021 Repl. Vol.).

The pertinent provisions of the Act provide the following:

> § 11-313. Denials, reprimands, probations, suspensions, and revocations -- Grounds
>
> Subject to the hearing provisions of § 11-315 of this subtitle, the Board, on the affirmative vote of a majority of its members then serving, may deny a license to any applicant, reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the applicant or licensee:
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> . . . .
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> (7) Willfully makes or files a false report or record in the practice of optometry;
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> . . . .
>
> (16) Grossly and willfully:
>
> . . . .

(ii) Submits false statements to collect fees for which services are not provided;

(17) Behaves immorally in the practice of optometry;

. . . .

(22) Violates any rule or regulation adopted by the Board;

(23) Commits an act of unprofessional conduct in the practice of optometry[.]

The pertinent provisions of Md. Code Regs. ("COMAR"), provide the following:

COMAR 10.28.06.04. Records.

A licensed optometrist shall maintain thorough records of all testing procedures, results, and case dispositions in accordance with Health-General Article, §4-403, Annotated Code of Maryland. The optometrist shall record all tests, evaluations, and observations performed, along with assessment and plan.

COMAR 10.28.14.03. General Conduct.

A. The licensee shall:

. . . .

(2) Make the fee for service clear, maintain adequate financial records, and confirm arrangements for financial reimbursement with the patient;

. . . .

B. In the capacity of or identity as a licensed optometrist, the licensee may not:

(1) Participate or condone dishonesty, fraud, deceit, or misrepresentation[.]

FINDINGS OF FACT

The Board and the Respondent have agreed to resolve the Charges following two Case Resolution Conferences, one held on May 25, 2022, and the second held on June 6, 2022.

I. Background

1. At all times relevant hereto, the Respondent was licensed to practice optometry in the State of Maryland. The Respondent was initially licensed in Maryland on or about February 20, 2001. The Respondent's license is currently active and scheduled to expire on June 30, 2023.

2. On or about February 23, 2021, the Board received a complaint from an investigator (the "Insurance Investigator") from an insurance company (the "Insurance Company") claiming:

> Member outreach was conducted and the members verified that Dr. Kalechi Mezu Nnabue billed for services not provided. The members said that they did not receive all of the services billed and said that they were not seen at the frequency of which the provider billed. The [Insurance Company's] investigation substantiated allegations of aberrant billing. Data analysis, member interviews and review of claims images showed that the provider billed an average of 13 claims per member and billed multiple services/claim lines on each claim.

3. The Respondent would testify at a hearing that to date, there has been no recoupment of funds from the Insurance Company. In addition, the Respondent would testify at the hearing that the Insurance Company never contacted her regarding the allegations set forth in its complaint.

4. If the case proceeded to a hearing, the Respondent would testify that the Respondent terminated the participation agreement with the Insurance Company effective March 2019.

5. Based on the Complaint, the Board began an investigation of the Respondent.

II. Board Investigation

6. As part of its investigation, the Board subpoenaed treatment and financial records from the Respondent for seven identified patients ("Patients 1-7"). The Board also obtained Health Insurance Claim Forms from the Insurance Company and conducted under-oath interviews of Patients 2 and Patient 6. The remaining patients were not interviewed by the Board. The Board notified the Respondent of the complaint and its subsequent investigation and provided the Respondent with the opportunity to respond in writing and in an under-oath interview with the Board.

7. On April 12, 2021, the Respondent provided a written response to the complaint where she denied allegations of fraudulent billing and other allegations and provided copies of treatment notes for Patients 1-7.

8. On April 23, 2021, the Board issued a Subpoena Duces Tecum to the Respondent, which stated in part:[1]

> Pursuant to Section 11-315 of the Health Occupations Article, Annotated Code of Maryland, **YOU ARE HEREBY SUMMONED AND COMMANDED** by the **MARYLAND STATE BOARD OF EXAMINERS IN OPTOMETRY** to deliver, **IMMEDIATELY** upon receipt of this subpoena, the following:

[1] The information was required to be return d to the Board within fifteen (15) days.

Copies of any and all relevant documents (in any form) on each of the patients listed below, including: files, medical records, financial records, bills and/or invoices, X-rays and/or photographs, insurance forms, appointment notes and/or logs, and any other related data or records. Please provide a duplicate copy of the actual record and, if any records are not legible, provide a typed or printed translation:

1. [Patient 1]
2. [Patient 2]
3. [Patient 3]
4. [Patient 4]
5. [Patient 5]
6. [Patient 6]
7. [Patient 7]

9. On or about May 21, 2021, the Respondent provided patient records and financial records for Patient 7.

10. On June 11, 2021, the Board issued a second Subpoena Duces Tecum to the Respondent, which stated in part:[2]

Pursuant to Section 11-315 of the Health Occupations Article, Annotated Code of Maryland, **YOU ARE HEREBY SUMMONED AND COMMANDED** by the **MARYLAND STATE BOARD OF EXAMINERS IN OPTOMETRY** to deliver, **IMMEDIATELY** upon receipt of this subpoena, the following:

Copies of any and all of the documents (in any form) that were subpoenaed for production to the Maryland State Board of Examiners in Optometry by May 21, 2021 and that have not been provided by you to the Maryland State Board of Examiners in Optometry, including financial records, bills and/or invoices, and insurance forms for each of the six

[2] The information was required to be returned to the Board within fifteen (15) days.

patients listed below. The information must include any and all such documents that correspond to the dates of service noted on the patient records provided to you to the Maryland State Board of Examiners in Optometry in response to the first Subpoena Duces Tecum on or about May 21, 2021.

1. [Patient 1]

2. [Patient 2]

3. [Patient 3]

4. [Patient 4]

5. [Patient 5]

6. [Patient 6]

11. On or about August 6, 2021, the Respondent provided a "Summary of Services – Addendum in Response to the Subpoena Duces Tecum dated 6/11/2021" along with billing receipts for the services rendered to six (6) patients.

12. In an interview with the Board's investigator on September 21, 2021, the Respondent reported the following under oath:

a. She first became aware of billing issues when a patient called her with an insurance company on the line, and the patient claimed that the Respondent had billed her thirteen times in a month. The insurer requested the Respondent's NPI number but was unable to locate the number in the insurer's system. In addition, the Respondent became aware of billing issues when her staff advised her that the office had received checks for individuals who were not patients of the Respondent.

b. The Respondent subsequently discovered that another health care provider was submitting claims to an insurance company (not the Insurance Company who filed the Complaint) using her National Provider Identifier ("NPI") and her practice information. She conducted an internal audit of her office policies, took corrective action, and referred the discrepancy to her attorney.

c. At the time of her interview, Respondent believed to the best of her knowledge that one check was received, never deposited, and sent back to the insurance company that had assigned her NPI number to another health care provider.

d. "Way back in 2017, 2018 time line, our office used a lot of interns . . . . my outgoing manager then trained them, . . . they are the ones that did a lot of the front desk work, the coding, the billing . . . . And if there were any mistakes or errors in billing in our office, then it was not malicious, it was not intentional and our office is [now] different."

e. "If there's anything that I did wrong, it would be trusting that the people working for me were proficient and good at what they do. Some of the issues that I found in my business, and which have been corrected now, is a lot of the staff were not billing when the patient comes in and that's where you might

have that discrepancy. For example, if on Friday, Saturday, maybe Thursday you had 30, 40 patients and you don't get to file those claims until a week or two weeks later. . . . What I found that was an error was a lot of [the staff] were filing the claims, but they were using the dates that they actually got to filing the claims, not the original dates that these patients came in, and that created a lot of confusion in my office."

f. She was unsure how claims and payments were received by the office in 2017, but she believed they were paid by direct deposit.

g. For the five visits that she provided records for Patient 3, those are the times that she saw that particular patient. "If there were any other dates of services or records that were submitted to [the Insurance Company], that was definitely in error."

h. Finally, she admitted that 2017 and 2018 was a difficult time "[a]nd between dealing with all my personal issues and working here and working at other places, I just did not put the time that I needed to do to see what my employees were doing."

13. By letter dated August 19, 2021, Senior Counsel for the insurance company[3] stated:

> We appreciate your bringing to our attention a claims processing error, which appears to have resulted in your office receiving remittances for a service provided by another service provider of another specialty, [Practice A]...Our findings show that...the claims processing system erroneously transmitted the remittances to the incorrect office...based on the fact that Practice A was not registered with the [insurance company] as a participating provider...we apologize for the inconvenience that has cause[d] and thank you again for bringing it to our attention.

Patient 1

14. A review of the Health Insurance Claim Forms obtained from the Insurance Company revealed eighteen (18) claims for payment for services for Patient 1 were

[3] This is the insurance company referenced in ¶ 12(b), not the insurance company referenced in the Complaint.

submitted for service dates of July 21, 2017 through November 29, 2018. The claims forms provide the following:

Date of Service	Claim ID Number	CPT/HCPCS Code(s)[4]	Total Billed Charge
July 21, 2017	XXXX5242	V2020,[5] V2100,[6] V2784,[7] 92340[8]	$666.00
December 8, 2017	XXXX9942	92012,[9] 92250,[10] 92225[11]	$435.00
December 26, 2017	XXXX2152	92004,[12] 92250, 92015[13]	$364.00
March 29, 2018	XXXX9206	92014,[14] 92250	$305.00
April 3, 2018	XXXX6844	92014, 92250	$305.00

[4] The Current Procedural Terminology ("CPT") code offers health care professionals a uniform language for coding medical services and procedures. All CPT codes are five-digits and can be either numeric or alphanumeric, depending on the category. The Healthcare Common Procedure Coding System ("HCPCS") is a standardized coding system used to process claims. The HCPCS is divided into two principal subsystems referred to as level I and level II. Level I is composed of CPT codes. Level II is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment. All CPT/HCPCS Code definitions contained herein were obtained from www.aapc.com/codes as accessed on December 29, 2021.

[5] The CPT/HCPCS Code V2020 refers to the purchase of spectacle frames.

[6] The CPT/HCPCS Code V2100 refers to sphere, single vision, plano to plus or minus 4.00, per lens.

[7] The CPT/HCPCS Code V2784 refers to lens, polycarbonate or equal, any index, per lens.

[8] The CPT/HCPCS Code 92340 refers to the fitting of eyeglasses, except for aphakia (absence of the crystalline lens as after cataract surgery); monofocal.

[9] The CPT/HCPCS Code 92012 refers to an established patient that the ophthalmologist sees for an intermediate level eye examination. Generally, a patient is considered to be "established" if the same physician, or any physician in the group practice (or any physician of the same specialty who is billing under the same group number), has seen the patient for a face–to–face service within the past 36 months.

[10] The CPT/HCPCS Code 92250 refers to the taking of fundus photographs, that is, photographs of the posterior segment of the inner aspect of the eye, to document alterations in the optic nerve head, retinal vessels, and retinal epithelium. It can be used to document baseline retinal findings and track disease progression.

[11] The CPT/HCPCS Code 92225 refers to an initial extended ophthalmoscopy indicating that the clinician has gone beyond a routine exam of the retina. Effective January 1, 2020, the code was deleted and replaced with CPT Code 92201.

[12] The CPT/HCPCS Code 92004 refers to the performance of a comprehensive level ophthalmological evaluation of a new patient and initiation of a diagnostic and treatment program for one or more visits.

[13] The CPT/HCPCS Code 92015 refers to an ophthalmological examination and evaluation.

[14] The CPT/HCPCS Code 92014 refers to an ophthalmologist who sees an established patient for a comprehensive level eye examination. Generally, a patient is considered to be "established" if the same physician, or any physician in the group practice (or any physician of the same specialty who is billing under the same group number), has seen the patient for a face–to–face service within the past 36 months.

May 31, 2018	XXXX9024	92014, 92250, 92225	$445.00
June 14, 2018	XXXX2409	92014, 92250	$305.00
July 3, 2018	XXXX6920	92014, 92250, 92225	$445.00
July 13, 2018	XXXX8571	92012, 92250	$305.00
August 15, 2018	XXXX8258	92014, 92250	$305.00
September 1, 2018	XXXX5151	92014, 92250	$305.00
September 15, 2018	XXXX5259	92012, 92250	$305.00
September 28, 2018	XXXX8759	92014, 92250	$305.00
October 12, 2018	XXXX3743	92012, 92250	$305.00
October 20, 2018	XXXX1401	92014, 92250	$305.00
October 26, 2018	XXXX4069	92012, 92225	$305.00
November 16, 2018	XXXX3858	92014, 92250	$305.00
November 29, 2018	XXXX4002	92014, 92250	$305.00

15. For each of the Health Insurance Claim Forms the Respondent is identified as the servicing provider, the facility where the Respondent was employed is identified as the billing provider, and the Respondent's name appears on line 31 which states "SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)"[15]

16. In response to the two subpoenas the Board issued to the Respondent, the Respondent only provided the Board with copies of treatment records and "Statement of Charges and Payments" for seven (7) of the dates of service: July 21, 2017; December 8,

[15] The reverse of the standardized Health Insurance Claim Form provides that the physician or supplier certifies, among other things, that the information on the form is true, accurate and complete and the services listed "were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction."

2017; April 3, 2018; May 31, 2018; June 14, 2018; September 15, 2018; and October 12, 2018.

17. Patient 1 was not interviewed by the Board. Instead, the Board Investigator interviewed Patient 1's mother on June 3, 2021 who stated that it was inaccurate that Patient 1 was seen and/or treated on eighteen (18) occasions from 2017 to 2018.

Patient 2

18. A review of the Health Insurance Claim Forms obtained from the Insurance Company revealed seventeen (17) claims for payment for services for Patient 2 were submitted for service dates of December 21, 2017 through November 1, 2018. The claims forms provide the following:

Date of Service	Claim ID Number	CPT/HCPCS Code(s)	Total Billed Charge
December 21, 2017	XXXX1158	92014, 92015, V2020, 92340, V2100	$671.00
December 27, 2017	XXXX5569	92004, 92250, 92225	$435.00
January 4, 2018	XXXX0904	92014, 92250	$305.00
February 26, 2018	XXXX1941	92014, 92250	$285.00
May 18, 2018	XXXX5131	92012, 92250	$305.00
June 8, 2018	XXXX9794	92014, 92250	$305.00
June 30, 2018	XXXX7817	92014, 92250	$305.00
July 27, 2018	XXXX4735	92014, 92250	$305.00
August 25, 2018	XXXX7810	92014, V2521,[16] 92015, 92250, 92310,[17] 92225	$873.00
September 1, 2018	XXXX5051	92014, 92250, 92225	$445.00

[16] The CPT/HCPCS Code V2521 refers to contact lens, hydrophilic, toric or prism ballast, per lens.

[17] The CPT/HCPCS Code 92310 refers to the provider performance of all components of contact lens prescription and fitting for both eyes except when there is absence of the lens of the eye (aphakia) as a result of prior cataract surgery.

September 11, 2018	XXXX2656	92014, 2026F,[18] 92250, 92225	$595.00
September 18, 2018	XXXX5406	92014, 2024F,[19] 92250	$455.00
September 22, 2018	XXXX4779	92014, 92250	$305.00
October 1, 2018	XXXX3929	92014, 92250	$305.00
October 13, 2018	XXXX1071	92014, 92250	$305.00
October 20, 2018	XXXX2559	92014	$155.00
November 1, 2018	XXXX3051	92014, 92250	$305.00

19. For each of the Health Insurance Claim Forms the Respondent is identified as the servicing provider, the facility where the Respondent was employed is identified as the billing provider, and the Respondent's name appears on line 31 which states "SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)"

20. In response to the two subpoenas the Board issued to the Respondent, the Respondent only provided the Board with copies of treatment records and "Statement of Charges and Payments" for four (4) of the dates of service: December 21, 2017; August 25, 2018; September 11, 2018; and September 18, 2018.

[18] The CPT/HCPCS Code 2026F refers to a physical examination where the ophthalmology or optometry provider uses other eye imaging to validate 7 standard field stereoscopic retinal photo results in a patient with diabetic retinopathy. The provider reviews and documents the findings in the patient's chart.

[19] The CPT/HCPCS Code 2024F refers to photos of the eye in seven standard fields in a diabetic patient with evidence of diabetic retinopathy. The provider interprets the findings and documents them in the patient's chart.

21. In an interview with the Board's investigator on June 2, 2021, Patient 2 reported the following:

a. Patient 2 has been a patient of the Respondent since 2012. She stated that she sees the Respondent every six months for an eye exam.

b. Patient 2 wears contacts.

c. Patient 2 stated that she visited the Respondent approximately two times in 2018.

d. Patient 2 estimated that "it might have been twice" that she visited the Respondent in 2018.

Patient 3

22. A review of the Health Insurance Claim Forms obtained from the Insurance Company revealed fifteen (15) claims for payment for services for Patient 3 were submitted for service dates of September 27, 2017 through June 27, 2019. The claims forms provide the following:

Date of Service	Claim ID Number	CPT/HCPCS Code(s)	Total Billed Charge
September 27, 2017	XXXX9524	92004, 92015, V2020, V2100, V2784, 92340, 92250, 92225	$1,150.00
February 23, 2018	XXXX4106	92014, 92250, 92225	$435.00
April 25, 2018	XXXX9703	92014, 92250, 92225	$445.00
May 24, 2018	XXXX8999	92014, 92250	$305.00
June 1, 2018	XXXX6998	92014, 92250, 92225	$445.00
June 14, 2018	XXXX6729	92014, 92250	$305.00

June 23, 2018	XXXX0606	92014, 92015, 92250, 92340, V2020, V2100, V2784, 92225	$1,220.00
July 13, 2018	XXXX8920	92014, 92250	$305.00
August 8, 2018	XXXX6779	92014, 92250	$305.00
August 15, 2018	XXXX9494	92012	$155.00
August 31, 2018	XXXX4249	92014, 92250	$305.00
September 10, 2018	XXXX0517	92014, 92225, 92250	$445.00
September 24, 2018	XXXX9651	92014, 92250	$305.00
October 6, 2018	XXXX4267	92012, 92250	$305.00
June 27, 2019	XXXX5615	92014, 92250, 92225, 92015, V2020, 92340	$692.00

23. For each of the Health Insurance Claim Forms the Respondent is identified as the servicing provider, the facility where the Respondent was employed is identified as the billing provider, and the Respondent's name appears on line 31 which states "SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)"

24. In response to the two subpoenas the Board issued to the Respondent, the Respondent only provided the Board with copies of treatment records and "Statement of Charges and Payments" for five (5) of the dates of service: September 27, 2017; February 23, 2018; June 1, 2018; June 23, 2018; and June 27, 2019.

25. The Board did not interview Patient 3 to inquire whether they received care from the Respondent on the dates set forth in the Health Insurance Claim Form.

Patient 4

26. A review of the Health Insurance Claim Forms obtained from the Insurance Company revealed sixteen (16) claims for payment for services for Patient 4 were submitted for service dates of September 27, 2017 through June 27, 2019. The claims forms provide the following:

Date of Service	Claim ID Number	CPT/HCPCS Code(s)	Total Billed Charge
September 27, 2017	XXXX0018	92004, 92015, V2020, V2100, V2784, 92340, 92250, 92225	$1,150.00
October 10, 2017	XXXX9684	92014, 92015, 92250, 92225	$474.00
October 26, 2017	XXXX9270	92014, 92015, 92340, V2020, V2784, V2100	$890.00
November 1, 2017	XXXX2174	92014, 92225, 92250	$450.00
February 23, 2018	XXXX4090	92012, 92250, 92225	$435.00
April 6, 2018	XXXX9633	92014, 92250	$305.00
June 14, 2018	XXXX6705	92014, 92250	$305.00
June 23, 2018	XXXX0634	92014, 92015, 92250, 92225, V2020, 92340, V2100, V2784	$1,220.00
July 14, 2018	XXXX3032	92014, 92250	$305.00
August 8, 2018	XXXX6836	92012, 92250	$305.00
August 31, 2018	XXXX4151	92014, 92250	$305.00
September 8, 2018	XXXX0494	92014, 92250	$305.00
September 28, 2018	XXXX5232	92014, 92250	$305.00
October 8, 2018	XXXX4167	92014, 92250	$305.00
November 3, 2018	XXXX4862	92014, 92250	$305.00
June 27, 2019	XXXX1022	92014, 92015, 92225, 92250, V2020, V2784, 92340	$961.00

27. For each of the Health Insurance Claim Forms the Respondent is identified as the servicing provider, the facility where the Respondent was employed is identified as the billing provider, and the Respondent's name appears on line 31 which states "SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)"

28. In response to the two subpoenas the Board issued to the Respondent, the Respondent only provided the Board with copies of treatment records and "Statement of Charges and Payments" for four (4) of the dates of service: October 10, 2017; February 23, 2018; June 23, 2018; and June 27, 2019.

29. The Board did not interview Patient 3 to inquire whether they received care from the Respondent on the dates set forth in the Health Insurance Claim Form.

Patient 5

30. A review of the Health Insurance Claim Forms obtained from the Insurance Company revealed fourteen (14) claims for payment for services for Patient 5 were

submitted for service dates of September 28, 2017 through October 15, 2018. The claims forms provide the following:

Date of Service	Claim ID Number	CPT/HCPCS Code(s)	Total Billed Charge
September 28, 2017	XXXX9797	92004, 92015, V2520,[20] 92310, 92225, 92250	$843.00
December 27, 2017	XXXX5622	92004, 92250, 92225	$435.00
April 17, 2018	XXXX9910	92014, 92250, 92225	$445.00
May 31, 2018	XXXX8971	92014, 92250	$305.00
June 14, 2018	XXXX6619	92014, 92250, 92225	$445.00
June 23, 2018	XXXX0685	92014, 92015, V2520, 92310, 92250, 92225	$2,202.00
June 27, 2018	XXXX4975	92014, 92250	$295.00
July 14, 2018	XXXX3004	92014, 92250	$305.00
August 8, 2018	XXXX6817	92014, 92250, 92225	$445.00
August 31, 2018	XXXX4209	92250, 92014	$305.00
September 7, 2018	XXXX0434	92014, 92250	$305.00
September 27, 2018	XXXX4928	92014, 92015, 92310, V2520, 92250	$1,962.00
October 13, 2018	XXXX4237	92014, 92250	$305.00
October 15, 2018	XXXX4874	92014, 92250, 92225	$445.00

31. For each of the <u>Health Insurance Claim Forms</u> the Respondent is identified as the servicing provider, the facility where the Respondent was employed is identified as the billing provider, and the Respondent's name appears on line 31 which states "SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)"

[20] The CPT/HCPCS Code V2520 refers to contact lens, hydrophilic, spherical, per lens.

32. In response to the two subpoenas the Board issued to the Respondent, the Respondent only provided the Board with copies of treatment records and "Statement of Charges and Payments" for one (1) of the dates of service: June 23, 2018.

33. The Board did not interview Patient 5 to inquire whether they received care from the Respondent on the dates set forth in the Health Insurance Claim Form.

Patient 6

34. A review of the Health Insurance Claim Forms obtained from the Insurance Company revealed twenty-four (24) claims for payment for services for Patient 6 were submitted for service dates of November 28, 2017 through June 22, 2019. The claims forms provide the following:

Date of Service	Claim ID Number	CPT/HCPCS Code(s)	Total Billed Charge
November 28, 2017	XXXX9529	92004, 92015, 92250, 92310, V2520, 92225	$833.00
December 1, 2017	XXXX9674	92014, 92250, 92225	$405.00
December 14, 2017	XXXX5669	92012, 92250	$305.00
December 19, 2017	XXXX4334	92014, 92250, 92225	$435.00
January 4, 2018	XXXX0836	92014, 92250, 92225	$435.00
January 18, 2018	XXXX9171	92014, 92225, 92250	$435.00
January 29, 2018	XXXX4196 XXXX1387 XXXX4151	92014, 92250	$305.00 $305.00 $305.00
March 8, 2018	XXXX3649	92014, 92250	$305.00
March 26, 2018	XXXX8895	92012, 92250, 92225	$435.00
April 24, 2018	XXXX5268	92014, 92250	$305.00
May 4, 2018	XXXX5283	92014, 92250, 92225	$445.00
June 7, 2018	XXXX1809	92014, 92250, 92225	$445.00
July 2, 2018	XXXX1221	92012, 92250	$305.00
August 3, 2018	XXXX4784	92014, 92250	$305.00
August 20, 2018	XXXX5819	92014, 92250	$305.00

September 7, 2018	XXXX2907	92014, 92250	$305.00
September 15, 2018	XXXX0099	92014, 92250	$305.00
September 28, 2018	XXXX8801	92012, 92250	$305.00
October 12, 2018	XXXX1078	92012, 92250	$305.00
November 10, 2018	XXXX4588	92014, 92250	$305.00
December 8, 2018	XXXX9310	92014, 92250	$305.00
May 15, 2019	XXXX1836	92014, 92250, 92225	$445.00
June 4, 2019	XXXX9733	92014, 92250, 92225, 92015	$504.00
June 22, 2019	XXXX1291	92014, 92015, 92250	$364.00

35. For each of the Health Insurance Claim Forms the Respondent is identified as the servicing provider, the facility where the Respondent was employed is identified as the billing provider, and the Respondent's name appears on line 31 which states "SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)"

36. In response to the two subpoenas the Board issued to the Respondent, the Respondent only provided the Board with copies of treatment records and "Statement of Charges and Payments" for nineteen (19) of the dates of service: November 28, 2017; December 1, 2017; December 14, 2017; December 19, 2017; January 4, 2018; January 18, 2018; January 29, 2018; March 8, 2018; March 26, 2018; May 4, 2018; June 7, 2018; July 2, 2018; August 3, 2018; August 20, 2018; September 7, 2018; September 15, 2018; October 12, 2018; November 10, 2018; and June 4, 2019.[21]

[21] Additionally, the Respondent provided the Board with a copy of the treatment records for the May 15, 2019, date of service. However, the Respondent failed to provide the Board with a copy of the financial records for the May 15, 2019, date of service.

37. In an interview with the Board's investigator on June 3, 2021, Patient 6 reported the following:

a. Patient 6 denied being seen and/or treated by the Respondent on twenty-four occasions between 2018 and 2019.

Patient 7

38. A review of the Health Insurance Claim Forms obtained from the Insurance Company revealed twenty (20) claims for payment for services for Patient 7 were submitted for service dates of January 4, 2018 through March 28, 2019. The claims forms provide the following:

Date of Service	Claim ID Number	CPT/HCPCS Code(s)	Total Billed Charge
January 4, 2018	XXXX1871	92014, 92250	$1,131.00
January 17, 2018	XXXX0928	92014, 92015, 92340, V2020, V2100, V2784, 92250, 92225	$305.00
January 29, 2018	XXXX4115	92014, 92250	$155.00
February 23, 2018	XXXX4054	92014	$494.00
March 9, 2018	XXXX8727	92014, 92015, 92250, 92225	$435.00
May 8, 2018	XXXX3696	92014, 92250, 92225	$445.00
May 31, 2018	XXXX9232	92012, 92250, 92225	$1,220.00
June 7, 2018	XXXX1781	92014, 92015, 92250, 92225, V2020, V2100, V2784, 92340	$305.00
June 14, 2018	XXXX6440	92014, 92250	$445.00
July 3, 2018	XXXX6888	92014, 92250, 92225	$305.00
July 13, 2018	XXXX8576	92014, 92250	$305.00
August 17, 2018	XXXX8774	92014, 92250	$305.00
September 6, 2018	XXXX5397	92014, 92250	$305.00
September 22, 2018	XXXX0181	92014, 92250	$305.00

November 3, 2018	XXXX4482	92014, 92250	$295.00
November 19, 2018	XXXX4537	92014, 92255	$733.00
March 8, 2019	XXXX9577	92014, V2520, 92310, 92015, 92250	$445.00
March 13, 2019	XXXX9599	92014, 92225, 92250	$821.00
March 21, 2019	XXXX2894	92014, 92250, 92015, V2020, V2784, 92340	$305.00
March 28, 2019	XXXX8736	92012, 92250	$1,131.00

39. For each of the Health Insurance Claim Forms the Respondent is identified as the servicing provider, the facility where the Respondent was employed is identified as the billing provider, and the Respondent's name appears on line 31 which states "SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)"

40. In response to the two subpoenas the Board issued to the Respondent, the Respondent only provided the Board with copies of treatment records and "Statement of Charges and Payments" for four (4) of the dates of service: January 17, 2018; February 23, 2018; June 14, 2018; and March 21, 2019.[22]

41. Patient 7, age 23, was not interviewed by the Board.

42. Instead, the Board's investigator interviewed Patient 7's mother on June 3, 2021, who stated:

a. Patient 7's eyes are bad and that she wears glasses.

[22] Additionally, the Respondent provided the Board with a copy of the treatment records for the March 8, 2019, date of service. However, the Respondent failed to provide the Board with a copy of the financial records for the March 8, 2019, date of service.

b. It was not accurate that Patient 7 was seen and/or treated on twenty (20) occasions from 2018-2019.

43. If the case proceeded to a hearing, the Respondent would testify that some claims were rejected by the Insurance Company and not paid, that she did not receive reimbursement for all charges billed for Patients 1-7, and some charges were paid at the negotiated reimbursement rate of 30-40% of billed charges.

CONCLUSIONS OF LAW

The Respondent's actions, as set forth above, constitute violations of: § 11-313(22) (violates any rule or regulation adopted by the Board); COMAR 10.28.06.04 (a licensed optometrist shall maintain thorough records of all testing procedures, results, and case dispositions in accordance with Health-General Article, §4-403, Annotated Code of Maryland. The optometrist shall record all tests, evaluations, and observations performed, along with assessment and plan); and COMAR 10.28.14.03(A)(2) (make the fee for service clear, maintain adequate financial records, and confirm arrangements for financial reimbursement with the patient).

The Board was not able to determine what charges billed to Patients 1-7 were accepted by the insurance company and paid and which charges were rejected by the insurance company and not paid. Of the claims that were paid, the Board was not able to determine the rate of reimbursement of any billed charges. As such, the Board has agreed to dismiss the Charges under Health Occ. § 11-313(7) (willfully makes or files a false report or record in the practice of optometry); § 11-313(16)(ii) (gross and willfully submits false statements to collect fees for which services are not provided); § 11-

313(17) (behaves immorally in the practice of optometry); § 11-313(23) (Commits an act of unprofessional conduct in the practice of optometry); and COMAR 10.28.14.03B(1) (In the capacity of or identity as a licensed optometrist, the licensee may not participate or condone dishonesty, fraud, deceit, or misrepresentation).

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, and upon the affirmative vote of a majority of the members of the Board it is hereby:

ORDERED, within **THIRTY (30) DAYS** of the date of this Order, the Respondent shall pay a fine of $1000 by check or money order made payable to the Board; and it is further

ORDERED, within **THREE (3) MONTHS** of the effective date of this Order, the Respondent shall successfully enroll in and complete two (2) hours of Board - approved courses on **ETHICS**, approved in advance by the Board; and it is further

ORDERED, within **THREE (3) MONTHS** of the effective date of this Order, the Respondent shall successfully enroll in and complete two (2) hours of Board - approved courses on **RECORDKEEPING**, approved in advance by the Board; and it is further

ORDERED, within **THREE (3) MONTHS** of the effective date of this Order, the Respondent shall successfully enroll in and complete two (2) hours of Board - approved courses on **MEDICAL BILLING/INSURANCE CODING**, approved in advance by the Board; and it is further

ORDERED, within **THREE (3) MONTHS** of the date of the effective date of the Consent Order, the Respondent shall provide the Board with written documentation of her successful completion of the courses required by this Consent Order; and it is further

ORDERED, that no part of the training or education that the Respondent receives in order to comply with the Consent Order may be applied to her continuing education credits required for certification or licensure; and it is further

ORDERED that beginning on the effective date of this Consent Order, the Respondent shall be placed on **PROBATION** for **THREE (3) YEARS**, during which time the Respondent shall successfully complete the following probationary conditions:

1. During the probationary period, the Respondent shall be supervised by a Board-approved supervisor who is a Maryland licensed optometrist, in good standing with no prior discipline ("Probation Supervisor"), which shall satisfy the following criteria:

    a. The Respondent shall engage the services of a Probation Supervisor within thirty (30) days of the effective date of the Consent Order;

    b. The Respondent shall make her records available for inspection by the Probation Supervisor;

    c. The Respondent shall provide the Probation Supervisor with a copy of this Consent Order prior to their initial meeting, and the Board may release to the Probation Supervisor any portion of the investigative file requested by the Probation Supervisor;

    d. The Respondent must have on a quarterly basis, direct, on-site supervision of Respondent's practice by the Probation Supervisor;

    e. The Probation Supervisor must review ten (10) random charts on a quarterly basis. The Probation Supervisor must review the charts for adequate documentation of clinical diagnosis, billing and fee arrangements to ensure that the recordkeeping is consistent with the Act;

f. The Respondent shall ensure that the Probation Supervisor provides the Board with written quarterly reports to the Board by the Probation Supervisor, evidencing that Respondent's practice is fully compliant with all standards for adequate documentation of clinical diagnosis, billing and fee arrangements to ensure that the recordkeeping is consistent with the Act;

g. The Respondent is responsible for ensuring that the Probation Supervisor submits the required reports to the Board in a timely manner;

h. A quarterly report from the Probation Supervisor, that cites material violations of this Consent Order as determined by a quorum of the Board may constitute a violation of this Consent Order;

i. The Respondent shall abide by any and all reasonable recommendations made by the Probation Supervisor. Failure to cooperate and failure to abide by the Probation Supervisor's recommendations may be deemed a violation of this Order by a quorum of the Board;

j. The Board may, in its discretion, implement reasonable changes in the supervision and approve or deny any proposed changes in the supervision;

k. In the event that the Probation Supervisor discontinues supervising the Respondent for any reason, the Respondent shall immediately notify the Board. The Respondent shall submit a replacement candidate to the Board for approval to serve as her Probation Supervisor under the terms specified above. Only the period of time during the probationary period where the Respondent is supervised counts towards fulfillment of the probation;

l. The cost, if any, of such supervision shall be borne by the Respondent; and it is **ORDERED** that the Respondent shall comply with the Maryland Optometry Act and all laws, statutes and regulations pertaining thereof; and it is

ORDERED that the Respondent may petition for early termination of probation after TWO (2) years;

ORDERED that at the conclusion of the probationary period, the Respondent may petition the Board for a termination of her probation. The Board may terminate the Respondent's probation if she has fulfilled all of the terms and conditions of the Consent Order, and there are no pending charges against her;

ORDERED that if the Board has reason to believe that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Respondent shall be given notice of a violation of probation and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be an evidentiary hearing before the Board. If there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board;

ORDERED that after the appropriate hearing, if the Board determines that the Respondent has failed to comply with any material term or condition of probation or this Consent Order, the Board may impose any disciplinary sanction available to it under the Act;

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order, including supervision;

ORDERED that the effective date of this Consent Order is the date the Consent Order is signed by the Board; and

ORDERED that the Consent Order is a Final Order of the Maryland Board of Examiners in Optometry and as such is a **PUBLIC DOCUMENT** which shall be posted to the Board's website and is reportable to any entity whom the Board is obligated to report

pursuant to Md. Code Ann., Gen. Prov. §§ 4-101 *et seq*. (2019 Repl. Vol. & 2021 Supp.) and Health Occ. § 1-607.

FOR THE BOARD

Original Signature on File
Gwendolyn A. Joyner, Executive Director
Maryland Board of Examiners in Optometry

Entered: 9/8/2022

CONSENT

By this Consent, I acknowledge that I have read the foregoing Consent Order in its entirety. I acknowledge the validity of this Consent Order, the Findings of Fact, and accept the Conclusions of Law and Order, as if entered into after the conclusion of a formal evidentiary hearing in which I would have the right to legal counsel authorized to practice law in Maryland, to confront witnesses, to give testimony, to request subpoenas for witnesses, to call witnesses on my own behalf, to introduce testimony and evidence on my own behalf, and to all other substantive and procedural protections provided by law. I waive these rights, as well as any appeal rights under § 10-222 of the Annotated Code of Maryland, State Government Article.

I sign this Consent Order, after having an opportunity to consult with legal counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning, terms and effect of this Consent Order.

KK Mezu

Kelechi Mezu Nnabue O.D.

NOTARIZATION

STATE: Maryland

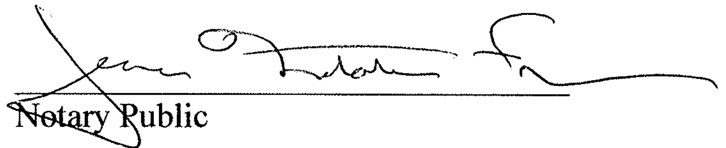
CITY/COUNTY: Baltimore

I HEREBY CERTIFY that on this 31st day of August, 2022, before me, Notary Public of the State and City/County aforesaid, **Kelechi Mezu Nnabue** personally appeared, and made oath in due form of law that signing the foregoing Consent Order was the voluntary act and deed of **Kelechi Mezu Nnabue**.

AS WITNESSETH my hand and notarial seal.

SEAL

JEANNE NATALIE FRASER
NOTARY PUBLIC
BALTIMORE COUNTY
MARYLAND
My Commission Expires 11/02/2023



Notary Public

My Commission Expires: 11/02/2023