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Medicaid Fraud Curator

December 7th, 2018

Total this week: $506M+

SourceURL: https://www.orlandosentinel.com/news/breaking-news/os-ne-medicaid-fraud-arrest-20181120-story.html

Owner of Orlando home health care business arrested in Medicaid fraud, investigators say

File (File)

The owner of an Orlando home health care business and an employee who worked there were arrested Monday after investigators said the owner defrauded Medicaid of more than $38,000, according to a warrant affidavit.

After interviews with former patients and employees and a review of the business' records, investigators said Neil Tormon, a certified respiratory therapist and the owner of Care Options Homecare Service in the 12000 block of Lake Underhill Road, falsely billed Medicaid for services not provided to patients. He also allowed unauthorized employees and sometimes unqualified people to provide care, according to the affidavit.

The investigation by the Attorney General's Medicaid Fraud Control Unit began in June, after an employee at the business suspected fraud and reported it to the Medicaid hotline after quitting, officials said in the affidavit.

One former patient who required necessary daily services told investigators a certified nurse was provided to her less than half the time, according to the affidavit. In the nurse's absence, the woman's elderly mother would care for her, investigators said.

The woman told investigators she spoke to employees while she was a patient "of her need for daily, consistent skilled nurses, including Care Options owner, Neil Tormon and nothing was done to correct the matter," according to the affidavit.

Still, the company billed Medicaid for full services, investigators said.

Tormon also allowed employee Maria Collins to bill Medicaid for two weeks in April 2017 that she said she worked, when she was really away on vacation, according to the affidavit. Collins told investigators Tormon told her she could do so because employees do not get paid vacations, the affidavit shows. Collins was arrested Monday on a grand theft charge.

Investigators said Tormon also allowed multiple Care Options employees to bill Medicaid after providing care for their relatives, which violates state law, according to the affidavit.

After one employee learned that he could not bill Medicaid for services to his wife, Tormon continued to allow it, and advised the employee to write a fake employee name on paperwork, according to the affidavit.

Torman was arrested on charges of obtaining property by fraud that's more than $20,000 but less than $50,000 and Medicaid fraud. He bonded out of the Orange County Jail Monday.

Tess Sheets can be reached at tsheets@orlandosentinel.com

Garland County woman arrested for Medicaid fraud

LITTLE ROCK — Arkansas Attorney General Leslie Rutledge recently announced the arrest of a Garland County woman for Medicaid fraud.

Tonashae Echols, 33, of Hot Springs, is the Therapy Manager of Little Bitty City Therapeutic Services in Hot Springs and is accused of making false statements regarding her family's income in order to receive Medicaid benefits for her children and billing Medicaid through the business for services provided to the children from November 2015 through July 2017. Following an investigation by the Attorney General's Office, Echols was arrested. She is charged with one count of Medicaid fraud, a Class B felony.

"Echols is accused of lying to collect benefits she was not entitled to receive," said Attorney General Rutledge. "When people cheat Medicaid, they steal from taxpayers and hurt a system designed to help the most vulnerable. I will not tolerate this behavior as the Attorney General."

An attorney with the Attorney General's Office will be sworn in as Special Deputy Prosecuting Attorney by 6th Judicial Prosecuting Attorney Larry Jegley.

Medicaid fraud occurs when providers use the Medicaid program to obtain money to which they are not entitled.

SourceURL: https://www.lexology.com/library/detail.aspx?g=ad2132bd-16b0-42c9-9ba5-7c6a72756dba

Dental Practice and Related Management Company Settle Medicaid Fraud Claims, Become the

First Entities on the OIG’s New “High Risk

Dental Practice and Related Management Company Settle Medicaid Fraud Claims, Become the First Entities on the OIG’s New “High Risk - Heightened Scrutiny” List Blog Health Law Advisor
A dental practice and related dental management company have become the first two entities to make their way on to the newly created “High Risk – Heightened Scrutiny” list from the Office of Inspector General for the United States Department of Health and Human Services (the “OIG”).

ImmediaDent of Indiana, LLC, a professional dental practice (“ImmediaDent”), and Samson Dental Partners, LLC, a dental management company which provides management and administrative services to ImmediaDent and other dental practices in Indiana, Kentucky and Ohio (“Samson”), jointly agreed on October 31, 2018 to an approximately $5.14 Million settlement with the Department of Justice and the OIG. The settlement stems from a *qui tam* suit brought by Dr. Jihaad Abdul-Majid, DDS, a dentist formerly employed by ImmediaDent. Dr. Abdul-Majid claimed that ImmediaDent and Samson perpetrated fraud against Indiana’s Medicaid program by way of upcoding certain tooth extraction procedures, in addition to improperly billing for tooth cleanings which were either not medically necessary or never performed. Interestingly, the settlement also involves claims that Medicaid fraud occurred in part due to Samson’s violation of Indiana’s prohibition on the corporate practice of dentistry. The theory proffered was that a pre-requisite to compliance with Indiana’s Medicaid program requirements was compliance with the law and regulations governing the practice of dentistry, including those requiring dentistry to only be practiced by licensed professionals. The government contended that Samson violated Indiana’s prohibition on the corporate practice of dentistry, and thus illegally engaged in the unlicensed practice of dentistry, by exerting undue influence over ImmediaDent’s dentists and other dental staff, including by way of rewarding production, disciplining those who did not meet production goals and directly interfering with clinical judgment.

The High Risk – Heightened Scrutiny list is a part of a new, five tier Fraud Risk Indicator system promulgated by the OIG to assess future risk posed by individuals and entities that have been alleged to have engaged in healthcare fraud. The tiers range from “Low Risk – Self Disclosure” to “Highest Risk – Exclusion”. The second “riskiest” tier is “High Risk – Heightened Scrutiny”. As part of this tier, the Federal government has begun listing entities that it believes “pose a significant risk to Federal healthcare programs and beneficiaries” and further need additional oversight, *but* have refused the government’s request to enter into a Corporate Integrity Agreement (“CIA”).

Though not required by statute or regulation, CIAs are typically utilized by the government as part of settlement negotiations with providers and other entities alleged to have perpetrated healthcare fraud. CIAs are structured to monitor an entity’s compliance with Federal healthcare program requirements in order to show the OIG that it should waive its authority to exclude the entity from participation in Federal healthcare programs. CIAs involve significant expense, requiring the ongoing engagement of specialized external auditors, or independent review organizations, and substantial investments in compliance systems and processes. Thus, certain entities have fought the Federal government’s attempts to impose a CIA. As a result, some have viewed the Heightened Scrutiny list as the government’s attempt to publicly shame entities who have refused to enter into a CIA.

The Heightened Scrutiny list has only formally been in place since October 1, 2018, and thus it remains to be seen if the government will actively add other entities to this list, and further whether the list will serve as a deterrent to entities considering pushing back on the government’s attempts to impose a CIA.

SourceURL: https://www.newschannel5.com/news/murfreesboro-dentist-faces-federal-charges

Murfreesboro dentist faces federal charges

Jason Lamb

A Murfreesboro dentist faces federal charges that he scammed several insurance companies, and even TennCare, a program funded by tax dollars.

MURFREESBORO, Tenn. (WTVF) - A Murfreesboro dentist faces federal charges that he scammed several insurance companies, and even TennCare, a program funded by tax dollars.

TBI Agent Mike Cox minces no words when it comes to the problem of insurance fraud in Tennessee.
His division, the Medicaid Fraud Control Unit, was formed to fight just that problem.

Federal prosecutors say over the past 5 years, some of that fraud came from Dental Excellence -- with three offices in Murfreesboro and one in Lebanon.

Prosecutors say Richard Schott and Kendra Glenn submitted bogus claims to insurance companies including TennCare, so they could collect the money for procedures they never did.

Prosecutors say the two would also threaten to fire employees who raised concerns about what they were doing.

And the TBI, who investigated the case, say fraud like this can raise both your insurance premiums and your taxes.

"It may fall on the backs of taxpayers in some form or fashion or as a private citizen when you're getting your own insurance," Cox said.

And the TBI says when it or the feds bring down fraud charges, it's cases have to be exceptionally strong: as defendants can afford to pay for exceptionally skilled attorneys.

SourceURL: https://www.wftv.com/news/local/central-florida-medical-provider-accused-of-defrauding-thousands-from-medicaid/876687048

Central Florida medical provider accused of defrauding thousands from Medicaid

By: James Tutten , Len Kiese

Updated: Nov 21, 2018 - 8:59 PM
Central Florida medical provider accused of defrauding thousands from Medicaid

ORANGE COUNTY, Fla. - A Central Florida medical provider is accused of bilking the Medicaid system for thousands of dollars.

Investigators with the state attorney general's office said the owner of Care Options Homecare came up with a scheme to defraud the government and some of the clients who hired his company for services.

Investigators said this scheme went on for more than a year and a half and might have gone on longer if not for a former employee who tipped off authorities.ot only is the owner now in trouble, but another one of his employees was also put in jail on felony charges.

People searching online for home health services in Central Florida came across Care Options Homecare offering everything from skilled nursing services to physical and respiratory therapy.

But WFTV News found out Neil Tormon, the man who's run the agency since 2015, was just arrested on a warrant on suspicion of Medicaid provider and organized fraud.

Furthermore, one of his employees, Maria Collins, was arrested on suspicion of theft.

There was no response at the Care Options Orlando office when WFTV stopped by for answers.

But a 26-page probable cause affidavit spells out a "scheme to fraudulently bill the Medicaid system" to the tune of nearly $40,000.

Tormon is accused of directing employees to list the maximum authorized hours and not the service hours provided to clients, allowing non-qualified people to perform skilled nursing procedures, failing to provide the required employee trainings and then creating certification documents as if the training was properly completed.

In the end, state investigators found Tormon's clients "did not receive the skilled nursing services being billed to Medicaid, but instead sub-standard care from unqualified individuals, thus placing them at risk."

WFTV later found Tormon, out on bond, at his Orlando home, but he closed his garage without answering questions.

As part of his bond release, Tormon is not allowed to work in any capacity that allows Medicaid.

Tormon also had to surrender his passport.

The agency for the Health Care Administration is working to determine what will happen to his license and any clients left in limbo.

SourceURL: https://www.wral.com/former-ncsu-booster-gets-18-months-in-prison-for-medicaid-fraud/18045345/

Former NCSU booster gets 18 months in prison for Medicaid fraud

Posted 7:46 p.m. yesterday

Greensboro, N.C. — A former North Carolina State University football player accused of providing impermissible benefits to student-athletes was sentenced Thursday to 18 months in prison for federal bribery and money laundering charges in a Medicaid fraud scheme.

Eric Dewayne Leak, who played football for the Wolfpack in the late 1990s and early 2000s, has been the focus of a WRAL News investigation for more than five years, after N.C. State ordered him to stay off campus and away from its student-athletes.

Leak, who pleaded guilty in March, also was ordered to pay a $5,000 fine, and he agreed to pay $420,000 back to the government as part of his plea deal.

Court documents state that Leak paid more than $400,000 in kickbacks between October 2011 and December 2013 to people who recruited clients for Nature's

Reflections LLC, the behavioral health counseling business run by Leak and his wife, Emily.

In March 2013, the information charges, Leak wrote a check for $32,000 on the account of Nature's Reflections to ACG Financial Management Group, "which represented property derived from a specified unlawful activity, that is, paying kickbacks."

WRAL News began investigating Leak in 2013 about his contact with N.C. State football and basketball players even after the university ordered him to stay away. The university issued a disassociation letter in November 2011 and a trespass notice in October 2013 after some cars Leak owned had been ticketed on campus.

At that time, Leak told WRAL that Nature's Reflections helped fund his interests in sports management.

Federal investigators started looking at Leak's businesses and found evidence of Medicaid fraud.

Nature's Reflections billed Medicaid for $8.7 million between 2012 and 2014, more than any other counseling agency of its kind in the state. According to a 2015 search warrant, employees claimed Leak told them to "write service notes for services not rendered."

Bank records show various renovations at the Leaks' $1.5 million house, including a pool and an exercise room, were paid for with money from Nature's Reflections.

Leak has also run afoul of NCAA and state policies that prohibit college athletes from accepting gifts or financial benefits from boosters.

In a 2015, federal investigators seized a high-end sports car that Leak helped purchase for former N.C. State basketball player C.J. Leslie. Agents said the down payment for the car came from Nature's Reflections.

Leak has also been accused in court documents of stealing about $500,000 from former N.C. State football star David Amerson and former Greensboro high school football star Keenan Allen. At the time of the alleged theft, Leak and Amerson had a business partnership through Hot Shot Sports, a company that handled Amerson's finances during the playing season.

Iowa let major Medicaid provider keep $2.4M in overpayments

IOWA CITY — After a major provider agreed to stay in Iowa's troubled Medicaid program, a top aide to Gov. Kim Reynolds quietly signed a deal letting its hospitals and clinics keep $2.4 million in mistaken overpayments, according to records released Thursday.

UnityPoint Health threatened to quit Iowa's Medicaid program a year ago, saying it was at an impasse in contract negotiations with the managed care organization AmeriGroup. Its departure would have disrupted care for 54,000 Medicaid recipients statewide beginning April 1. But UnityPoint and AmeriGroup reached a last-minute agreement to keep the provider network in the program, a political victory for Reynolds.

Weeks later, Iowa Department of Human Services Director Jerry Foxhoven cut UnityPoint a break that allowed it to keep more than half of the overpayments that had been identified by a Medicaid audit, according to records obtained by The Associated Press.

The payments in question were incentives for using electronic health records that Iowa Medicaid had awarded to providers using federal funding earmarked for that purpose. Medicaid awarded UnityPoint hospitals and clinics $19.2 million between 2011 and 2015, but auditors last year found that was an overpayment of nearly $4.4 million due to miscalculations relating to the number of services provided.

The program sent letters to UnityPoint's affiliates demanding repayment in full, including from hospitals in Des Moines, Waterloo, Cedar Rapids and Rock Island, Illinois.

But the settlement, signed April 25 by Foxhoven, said UnityPoint would only have to refund half of the overpayments after appeals, up to a maximum of $2 million. DHS acknowledged in the agreement the overpayments weren't due to any "intentional misconduct" by UnityPoint.

UnityPoint argued the overpayments resulted from Iowa Medicaid's failure to verify and calculate the amounts it was owed under the incentives program, a charge that state officials denied. The agreement said the two sides were settling "for economic reasons, to buy peace, and to avoid the time, cost and uncertainties of contesting the matter."

A whistleblower alleged in a letter to Democratic state Sen. Joe Bolkcom the agreement was payback for UnityPoint's continued participation in Medicaid.

In an interview Thursday, Bolkcom said administration officials never informed lawmakers "that they made a $2.4 million decision to benefit one provider network" and questioned whether they had the authority to waive the collection of documented overpayments. He suggested the incoming state auditor, Democrat Rob Sand, should investigate the deal as part of his promised review of Medicaid.

"This just looks really fishy that this deal would be struck," Bolkcom said. "It would appear this was done to alleviate this political problem of a big provider literally dropping out of the managed care network."

UnityPoint spokeswoman Heather Nahas said the deal was unrelated to its decision to stay in Iowa's program, which has faced turmoil since its administration was turned over to for-profit managed care companies.

The agreement came as other hospitals and clinics were complaining that they weren't being paid in a timely manner and as some severely disabled residents and other patients reported having their services cut or denied. Despite the cuts, the privatization hasn't saved as much money as anticipated.

The AP requested a copy of the settlement agreement from DHS in early October. At the time, Medicaid was a central issue in the governor's campaign against Democrat Fred Hubbell, who had accused her of mismanaging the program and ran television ads highlighting the impact on the disabled.

DHS released a copy Nov. 9, days after Reynolds narrowly defeated Hubbell to win a four-year term. Additional records were released Thursday confirming UnityPoint's affiliates paid back $2 million earlier this year but an additional $2.4 million was waived.

SourceURL: https://www.wjhg.com/content/news/Bonifay-doctor-under-investigation-for-Medicaid-fraud-502110332.html

Bonifay doctor under investigation for Medicaid fraud

Medicaid Fraud Investigation

BONIFAY, Fla. (WJHG/WECP) - A Holmes County doctor's office is under fire because of alleged fraud.

The Florida Attorney General's office has confirmed there is an active Medicaid fraud investigation into Dr. Ahmad Tariq Ismail's office.

Ismail specializes in family medicine at the office located on East Byrd Avenue in Bonifay.

There are two other doctors at the practice.

A search warrant of the office was issued on Monday.

The Attorney General's office has denied further comment at this time.

SourceURL: https://onenewsnow.com/culture/2018/12/06/medicaid-audit-uncovers-louisiana-lagniappe

Medicaid audit uncovers Louisiana lagniappe

"Stunning and horrifying" is the response to a new report on Medicaid expansion in Louisiana under Obamacare.

In an attempt to study Medicaid's impact under the Affordable Care Act, Louisiana auditor Daryl G. Purpera selected 100 people deemed eligible for the program.

It turned out that a whopping 82 of them should never have qualified because they made too much money.

"It's stunning and horrifying," says Kristina Rasmussen, vice president of federal affairs at the Foundation for Government Accountability (FGA).

"Taxpayer dollars are going to provide welfare to people who don't qualify for it, who don't deserve it," she complains, "and every dollar that goes to a fraudster is every dollar that we can't send to the truly needy."

In a related article, T*he Washington Times* quoted Purpera as saying his finding is "huge" and he predicted that other state auditors, if they study the numbers, will conclude their own state is being defrauded, too.

The *Times* story said a federal inspector general pulled 150 Medicaid receipients in California and found 38 were ineligible.

"A similar report in California was released by their auditor and found problems with dead people being on the rolls, or people who are otherwise ineligible," Rasmussen tells OneNewsNow.

The problem now being uncovered, she advises, began with a nationwide "rush" to sign people up for Obamacare, which cut corners.

SourceURL: https://www.wyomingnews.com/news/local_news/former-psychologist-wife-sentenced-to-prison-for-medicaid-fraud/article_182656ca-f85e-11e8-95b2-330b6d4113dc.html

SourceURL: https://www.homecaredaily.com/2018/12/05/orlando-home-care-company-owner-faces-charges-of-medicaid-fraud/

Orlando Home Care Company Owner Faces Charges of Medicaid Fraud

By Valerie VanBooven, RN BSN, Editor in Chief of HomeCareDaily.com | December 5, 2018

The owner of an Orlando home health care company and an employee are facing charges of defrauding Medicaid. Neil Tormon is accused of falsely billing Medicaid for services that were not provided to clientele. This fraud netted approximately $38,000 from Medicaid.

One former client reportedly told authorities that a certified nurse was only sent to her home for less than half the time she had been approved for this level of care. When the nurse was not there, that client's elderly mother would take over the responsibility of caring for her. Yet, the Orlando home health care company charged for full services, even though they were not provided.

An employee at the company, Care Options, was permitted to bill Medicaid for services provided during a two-week period of time in which she was actually on vacation. Neil Tormon was also alleged to have permitted other employees to bill Medicaid for services provided to relatives, which violates state law.

As reported in the Orlando Sentinel, in the blog, *Owner of Orlando home health care business arrested in Medicaid fraud, investigators say*, written by Tess Sheets:

> *"After interviews with former patients and employees and a review of the business' records, investigators said Neil Tormon, a certified respiratory therapist and the owner of Care Options Homecare Service in the 12000 block of Lake Underhill Road, falsely billed Medicaid for services not provided to patients. He also allowed unauthorized employees and sometimes unqualified people to provide care, according to the affidavit.*
>
> *The investigation by the Attorney General's Medicaid Fraud Control Unit began in June, after an employee at the business suspected fraud and reported it to the Medicaid hotline after quitting, officials said in the affidavit."*

Even when one employee discovered that it was against state law to do so, Neil Tormon continued to authorize this type of billing, advising the employee to change the name on the form and list a fake employee instead. Tormon was charged with obtaining property by fraud that's more than $20,000 but less than $50,000 and Medicaid fraud. He was released on bond through the Orange County Jail the Monday before Thanksgiving.

It is unclear whether Mr. Tormon had obtained legal counsel yet or what charges his employee is facing for also attempting to defraud Medicaid for those two weeks while on vacation. It is also unclear whether other employees at the company will be facing charges for billing Medicaid for services provided to relatives.

Editor in Chief of HomeCareDaily.com at LTC Expert Publications

Valerie is a Registered Nurse, Author, and Co-Owner of LTC Expert Publications. Read More at http://www.LTCSocialMark.com

Summary

Article Name

Orlando Home Care Company Owner Faces Charges of Medicaid Fraud

Description

The owner of an Orlando home health care company and an employee are facing charges of defrauding Medicaid. Neil Tormon is accused of falsely billing Medicaid for services that were not provided to clientele. This fraud netted approximately $38,000 from Medicaid.

SourceURL: https://www.allongeorgia.com/georgia-state-news/georgia-resident-indicted-for-medicaid-fraud-and-elder-exploitation/

Georgia Resident Indicted for Medicaid Fraud and Elder Exploitation

The Office of the Attorney General has announced that Quanicia Wilson was indicted on November 7, 2018 for the following charges: one count of Violation of the Georgia Racketeer Influenced and Corrupt Organizations Act, five counts of Medicaid Fraud, one count of Exploitation of an Elder Person, one count of

Forgery, one count of False Statements and Writings and twenty-two counts of Theft by Taking. The case was presented in Gwinnett County Superior Court.

“In this case, unfortunately, we dealt with not only a complete disregard for the integrity of the Georgia Medicaid program, but someone’s willingness to exploit an elder relative for their own financial gain,” said Attorney General Chris Carr. “That’s simply unacceptable, and I’m proud of our Medicaid Fraud Control Division for their work on this case.”

Quanicia Wilson is the mother of Armani John-Charles, a Georgia Medicaid recipient, and the granddaughter of Beatrice MacIntyre, an eighty-six year old retired nurse. From July 2014 to November 2015, Ms. Wilson used Ms. MacIntyre to obtain $20,723.45 from the Georgia Medicaid program to which she was not entitled. Ms. Wilson fraudulently submitted an employment application to the Georgia Medicaid program, claiming she was hiring Ms. MacIntyre to provide personal support services to Mr. John-Charles. Ms. Wilson then submitted time sheets and electronically submitted hours to Acumen, a fiscal intermediary of the Georgia Medicaid program, claiming Ms. MacIntyre provided these services to Mr. John-Charles. However, Ms. MacIntyre never provided these services and was unaware of Ms. Wilson using her identity to obtain these payments.

During this same time period, Ms. Wilson also accessed bank accounts into which Ms. MacIntyre’s Social Security checks and pension from the Ohio Public Employees Retirement System were direct deposited. Wilson used these accounts as her own, at times transferring Ms. MacIntyre’s Social Security and pension funds from these accounts into her own personal checking accounts. In total, Ms. Wilson appropriated over $37,000.00 belonging to Ms. MacIntyre.

This case was investigated and prepared for prosecution by the Medicaid Fraud Control Division: Investigator Sadarius Miley, Nurse Investigator Nancy Goddard, Forensic Auditor William Deloach and Intelligence Analyst Vanda Russell. It is being prosecuted by Assistant Attorney General Amanda E. Love.

Prison sentence in Medicaid fraud case

CHEYENNE (WNE) — A former Cheyenne psychologist and his wife were sentenced to prison Monday for making false statements to Wyoming Medicaid.

John R. Sink Jr., 68, and his wife, Diane M. Sink, 63, will serve 37 months in prison and must pay more than $6.2 million back to the Wyoming Department of Health and the U.S. Department of Health and Human Services.

The Sinks also were ordered to forfeit more than $750,000 in assets connected to the fraud, including cash, retirement accounts, vehicles and a house, according to a news release from the U.S. attorney for Wyoming.

The husband and wife were indicted in May by a federal grand jury on charges of health-care fraud, making false statements and money laundering.

They pleaded guilty to making false statements earlier this year.

Prosecutors and law enforcement accused them of billing Wyoming Medicaid for $6.2 million in group therapy that never occurred or didn't qualify to be state funded.

In May 2016, Wyoming Medicaid audited the Sinks, and court documents accused them of asking their employees to create backdated or phony treatment plans.

"Health-care fraud is a serious crime that increases costs and wastes health-care dollars on medically worthless or unnecessary activities," U.S. Attorney Mark Klaassen said in a news release. "Fraud involving a government health-care program ... is even more serious because it wastes taxpayer dollars and reduces the program's ability to serve needy individuals and families."

The case was investigated by the FBI and Wyoming Medicaid Fraud Control Unit. Assistant U.S. attorney Eric Heimann and special assistant U.S. attorney Travis Kirchefer prosecuted the case.

SourceURL: https://skillednursingnews.com/2018/12/oig-touts-nearly-3b-medicare-medicaid-fraud-recoveries-fiscal-2018/

OIG Touts Nearly $3B in Medicare, Medicaid Fraud Recoveries in Fiscal 2018

By Alex Spanko | December 3, 2018

The Department of Health and Human Services' top fraud watchdog recovered nearly $3 billion from providers in fiscal 2018, a figure that included more than $18 million in improper payments at nursing homes.

The HHS Office of the Inspector General (OIG) touted its $2.91 billion haul in its most recent semiannual report to Congress, released at the end of last week, tallying 764 criminal actions and the removal of more than 2,700 providers from the approved Medicare and Medicaid rolls.

"OIG continues to fulfill its crucial mission for the American people by providing objective, actionable information and recommendations to improve fiscal stewardship and quality of services provided by HHS programs and by holding those who harm HHS programs accountable," inspector general Daniel Levinson wrote in the report.

The OIG's actions in fiscal 2018, which ended September 30, included flagging $18.4 million in Medicare spending on durable medical equipment related to skilled nursing facility stays that didn't qualify for Medicare coverage. In some cases, the OIG found, Medicare paid for equipment at nursing homes that were only approved to handle Medicaid residents. The Centers for Medicare & Medicaid Services (CMS) agreed to increase oversight of such payments going forward, as well as determine the potential costs and benefits of tracking the level of care provided in Medicaid-only buildings.

"CMS requires facilities to provide DME as a standard part of nursing care, and does not permit separate Medicare payment for DME except when Medicaid-only nursing facilities serve as beneficiary homes," the OIG noted in its report. "CMS uses two payment edits designed to identify and reject inappropriate claims, but neither edit rejected the claims because SNFs and DME suppliers did not submit full and accurate information required for processing."

The six-month reporting period — which stretched from April to September — also included the $30 million settlement that provider Signature HealthCARE agreed to pay in June to resolve allegations of fraudulent billing for rehab therapy services, as well as the capture of an OIG Most Wanted Fugitive with nursing-home ties. Etienne Allonce was accused of billing Medicare for wound care supplies that his Hicksville, N.Y.-based durable medical equipment company didn't actually provide. Allonce and his wife, Helene Michel, allegedly stole patient medical records from nursing homes in order to further their scheme, according to the OIG.

Allonce is currently being held pending formal charges, while Michel was sentenced to 12 years in prison after being convicted in 2013.

Phone tag

Each report to Congress features a breakdown of how the OIG receives tips regarding potential fraud at health care facilities, with HHS logging 60,390 calls to its confidential free tip line between April and September. Of that total, the OIG evaluated more than 11,000 tips, with 8,000 referred for further action. In all, the department estimates that the hotline alone pulled in $27 million in recovery funds during the six-month reporting period.

That's a significant uptick in calls from the mid-1990s, when the hotline was first established; writing in a 1996 semi-annual report to Congress, the OIG reported about 23,600 calls between June 1995 and March 1996.

Written by Alex Spanko

Photo Credit:

- fall-163496_1280: Pixabay | CC BY-SA 2.0

Alex Spanko

Alex covers the long-term health care industry for Aging Media Network, with a specific interest in the intersection of finance and policy. Outside of work, he reads nonfiction, experiments in the kitchen, enjoys pretty much any type of whiskey or scotch, and yells at Mets games — often all at the same time.

SourceURL: https://www.detroitnews.com/story/news/local/macomb-county/2018/12/06/feds-allege-six-detroit-area-doctors-fueled-opioid-crisis-health-care-fraud-conspiracy/2225239002/

Six Detroit-area doctors charged in $500M opioid scheme

Robert Snell, The Detroit News Published 10:58 a.m. ET Dec. 6, 2018 | Updated 9:10 p.m. ET Dec. 6, 2018

Rajendra Bothra(Photo: The Pain Center)

Detroit — Six doctors were charged in an unsealed indictment Thursday with cheating Medicare and Medicaid out of almost $500 million and fueling the nation's opioid epidemic by illegally prescribing more than 13 million doses of prescription pain medication.

The dollars and drugs involved make the alleged health care fraud conspiracy one of the largest in Michigan history, and one of the largest nationwide.

The scheme was focused within three pain clinics in Macomb County. They are The Pain Center USA in Warren and Eastpointe, and Interventional Pain Center in Warren.

The three clinics were owned and operated by Dr. Rajendra Bothra, 77, of Bloomfield Hills, a surgeon, humanitarian and politician. In 1999, Bothra was presented with the highest civilian honor bestowed in India, known as the Padmashri.

Bothra was cited for humanitarian efforts in India, which included educating people about AIDS, the dangers of tobacco and alcohol, and fundraising efforts for medical equipment.

Bothra's clinics "sought to bill insurance companies for the maximum number of services and procedures possible with no regard to the patients' needs," prosecutors alleged.

"The damage that opioid distribution has done to our community and to the United States as a whole has been devastating," U.S. Attorney Matthew Schneider said in a statement Thursday. "Healthcare professionals who prey on patients who are addicted to opioids in order to line their pockets is particularly egregious."

The other doctors charged are:

• Dr. Eric Backos, 65, of Bloomfield Hills.

• Dr. Ganiu Edu, 50, of Southfield.

• Dr. David Lewis, 41, of Detroit.

• Dr. Christopher Russo, 50, of Birmingham.

• Dr. Ronald Kufner, 68, of Ada.

The doctors all worked in various capacities at Bothra's clinics and lured patients there by prescribing opioids, the indictment alleges.

After arriving at the clinics, patients received the pain medications and were forced to undergo treatments that included injections, according to the government.

Clockwise from left: Dr. Ganiu Edu, Dr. Eric Backos, Dr. David Lewis and Dr. Ronald Kufner (Photo: Handout)

Bothra and Lewis were arranged in federal court Thursday.

The disheveled doctors were arrested early Thursday and brought to court in handcuffs and ankle chains.

Bothra, his hair rumpled, sat next to Lewis on a courtroom bench while waiting to be arraigned. Lewis, dressed in a green T-shirt and black jeans with the pockets turned inside out, ignored Bothra, who sat silently.

Coincidentally, the doctors, charged in an opioid case, sat next to two men who were charged Thursday with distributing a lethal dose of fentanyl.

Bothra is being held without bond pending a detention hearing Friday in federal court. His lawyer declined comment.

Lewis was released on $10,000 unsecured bond, barred from prescribing drugs and billing Medicaid or Medicare.

His attorney also declined comment.

Russo and Edu also were released on $10,000 unsecured bond.

The 56-count indictment charges the six doctors with health-care fraud conspiracy, a 10-year felony, multiple counts of aiding and abetting health-care fraud and drug crimes.

The scheme started in January 2013 and continued until last month and involved charging Medicare, Medicaid and Blue Cross/Blue Shield of Michigan for medically unnecessary services and equipment, the indictment alleges.

The conspiracy cost Medicare more than $182.5 million, $272.6 million to Medicaid and $9.2 million to Blue Cross/Blue Shield, according to the indictment.

The doctors also were responsible for prescribing 13,217,987 doses of opioids, including OxyContin, Vicodin, hydrocodone and Percocet, the government alleges.

"Physicians who engage in the illegal and negligent prescribing of controlled substances in order to unjustly enrich themselves of taxpayer dollars will be held accountable" said Lamont Pugh III, special agent in charge, U.S. Department of Health & Human Services, Office of Inspector General.

Dr. Frank Patino, 63, of Woodhaven is awaiting trial in one of the largest health care fraud cases in U.S. history. (Photo: Facebook)

The allegations outlined in the complaint are "terrifying," said Monique Stanton, president and CEO of CARE of Southeastern Michigan, a Macomb County-based group that provides substance abuse treatment.

"It is imperative that those medical officials who abuse their powers for financial reasons are held accountable — we are in a life-and-death situation in this epidemic," Stanton wrote in an email Thursday. "Physicians see people at their most (vulnerable), especially those suffering from severe pain, so this is a major breach of trust to see them take advantage patients in this way."

The alleged conspiracy is the third totaling more than $100 million in recent years in Metro Detroit.

Dr. Frank Patino of Woodhaven was charged in June and accused of orchestrating a $112 million health-care fraud.

Prosecutors, court records and social-media posts portray Patino as a conniving crook with lies as big as his biceps, an alligator-wrestling, steroid-buying, frequently shirtless fraudster who spent ill-gotten gains on mixed martial arts fighters and a vanity diet program.

Patino is jailed while awaiting trial.

The Patino case is linked to an investigation involving a $200 million scheme and businessman Mashiyat Rashid of West Bloomfield Township. Prosecutors say Rashid spent his share of the scheme on a $7 million Franklin mansion, courtside NBA tickets, a Lamborghini, Hermes clothes and rare watches.

Federal prosecutors Monday flashed the cash, supercars and super bank accounts of Mashiyat Rashid, 37, of West Bloomfield Township, the accused architect of a $132 million health-care fraud scheme in a bid to keep him behind bars. (Photo: U.S. Attorney's Office)

The Rashid scheme distributed 6.6 million doses of controlled substances, federal authorities said.

During the Rashid investigation, federal agents have seized more than $21 million worth of cash and real estate and want Rashid's mansion forfeited to the government.

Rashid struck a plea deal with prosecutors in October

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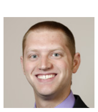
SourceURL: https://newsok.com/article/5616402/former-okc-counselor-gets-prison-for-medicaid-fraud

Former OKC counselor gets prison for Medicaid fraud



by Kyle Schwab

Published: Fri, November 30, 2018 5:00 AM

A former behavioral health counselor has been sentenced to a year in federal prison for fraudulently billing Medicaid for counseling he did not actually provide.

Samuel Okere, 62, of Oklahoma City, devised a scheme to unlawfully enrich himself by submitting false and fraudulent Medicaid claims to the Oklahoma Health Care Authority, according to Oklahoma City federal prosecutors.

Between 2013 and 2017, Okere billed for numerous counseling sessions, primarily with children, at times conflicting with his clients' schedules or his own whereabouts, prosecutors alleged. In one instance, he admitted he billed for a counseling session when he was actually at the YMCA.

District Judge Stephen Friot ordered Okere pay $141,545 in restitution. Okere has already fully paid the amount. The judge also ordered Okere pay a $10,000 fine.

“Samuel Okere took advantage of the system that some of the most vulnerable in our society rely on for health care services,” Oklahoma Attorney General Mike Hunter said.

The investigation found that Okere was submitting false claims for behavioral health counseling while he was a licensed professional counselor and owner of New Life Counseling Services.

Okere pleaded guilty to health care fraud in April. He was sentenced this week.

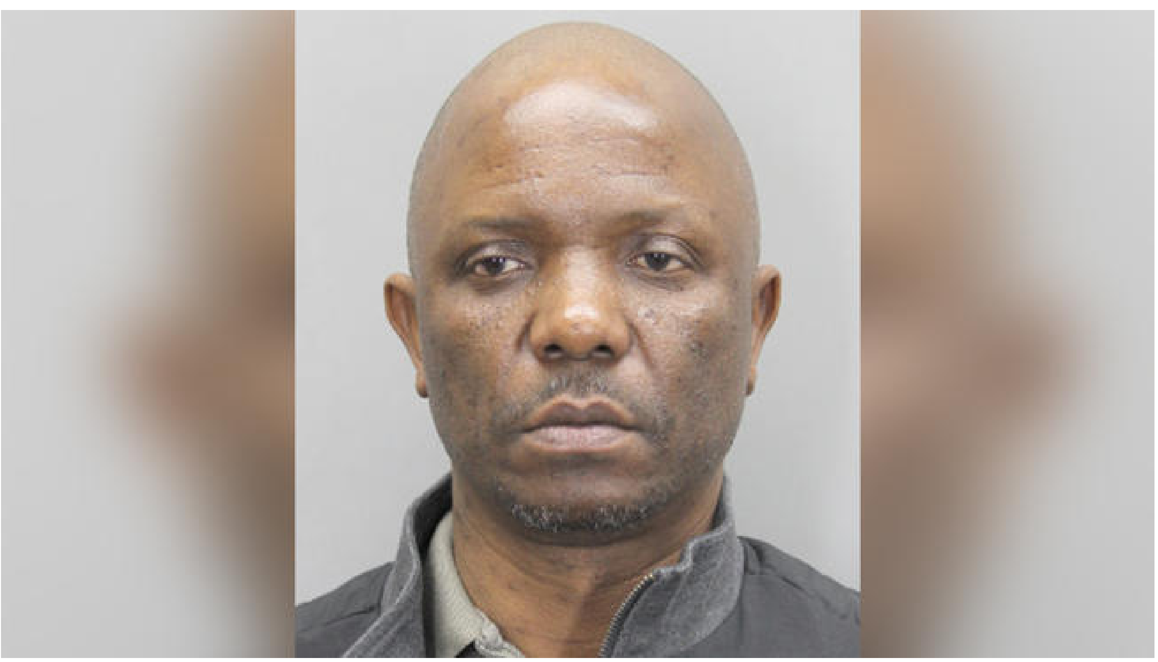
SourceURL: https://www.nbcwashington.com/news/local/Virginia-Medicare-Fraud-501822531.html

Home Health Care Company Head Accused of Fraudulently Charging $4.5M to Virginia Medicaid

A home health care company fraudulently charged Virginia Medicare $4.5 million, the state says

By Julie Carey and NBC Washington staff

Published Dec 3, 2018 at 9:45 PM | Updated at 10:00 PM EST on Dec 3, 2018



John Ndunguru, the president of home health care company Mercy Services of Health, was indicted on 12 charges. He's accused of fraudulently charging Virginia's Medicaid program $4.5 million.

The owner of a Fairfax County home health care company is behind bars accused of billing the state for millions in fraudulent claims.

The case emerges just as Virginia is poised to expand its Medicaid program.

John Ndunguru, the president of home health care company Mercy Services of Health, was indicted on 12 charges. He's accused of fraudulently charging Virginia's Medicaid program $4.5 million.

Court documents show that the agency that oversees Medicaid has already paid Ndunguru $3.6 million.

Investigators allege Ndunguru made false Medicaid claims on behalf of 59 patients who were not approved for long-term care.

Trina Greene, the Mercy Services office manager, says workers are devastated by the news but are standing behind the man they fondly call Doctor John.

Green and other employees saw signs of trouble last week when offices were raided by investigators from the attorney general's office. A search warrant shows 10 computers were seized along with 33 boxes of documents

The court documents also allege other issues at Mercy Services. Investigators say a doctor's signature was forged on some patient documents, required patient records were missing and Mercy Services failed to do criminal background checks on some home health care aides.

For now, Greene says Mercy Health employees plan to continue working. The company says it provides services to about 90 patients and employs about 100 home health care aides.

Ndunguru is not able to return to the office as he is being held without bond.

Dillwyn Couple Sentenced on Federal Healthcare Fraud Charges

Posted: Dec 06, 2018 9:58 AM CST Updated: Dec 06, 2018 11:34 AM CST

Department of Justice Press Release:

CHARLOTTESVILLE, VIRGINIA – A husband and wife, who enriched themselves by defrauding the Virginia Medicaid program, were sentenced this week in U.S. District Court on federal health care fraud and related charges, United States Thomas T. Cullen and Virginia Attorney General Mark Herring announced.

Dennis Gowin, 67, of Dillwyn, Va., was sentenced earlier this week to 12 months in prison, followed by two years of supervised release. He was also ordered to pay restitution in the amount of $210,593, and a fine of $5,500.

Gowin previously pleaded guilty to one count of health care fraud, one count of wrongful disclosure of individually identifiable healthcare information, and one count of possession of a firearm by a previously convicted felon.

Cheryl Gowin, 65, also of Dillwyn, was sentenced earlier this week to three years of probation with the first six months on house arrest, three years of supervised release, ordered to pay restitution in the amount of $210,593, and a $2,000 fine.

She previously pleaded guilty to one count of health care fraud and one count of wrongful disclosure of individually identifiable healthcare information.

“Healthcare fraud, in its various forms, costs the U.S. taxpayers billions of dollars every year and substantially reduces the quality of care for those who need it most,” U.S. Attorney Cullen stated today. “We are committed to working with our federal, state, and local partners, including the Virginia Attorney General’s Office, to prosecute those who exploit our health-care system and, in so doing, violate the public’s trust.”

“The Gowins defrauded taxpayers and families who trusted the couple to provide counseling and care to their loved ones,” Attorney General Herring said today. “We will continue to hold people like this to account when they break the law by lying, cheating, stealing from, or defrauding important healthcare programs.”

According to evidence presented at previous hearings by Assistant United States Attorney Ronald M. Huber, from May 2013 through February 2016, Dennis Gowin was a director of Hope for Tomorrow Counseling, an outreach program that provided mental health counseling to children, adolescents, adults, and families throughout the commonwealth.

Cheryl Gowin was likewise employed by Hope for Tomorrow as a Resident-in-Counseling (i.e. counselor in training).

In addition, Dennis Gowin was the executive director of Discovery Counseling-Virginia, a counseling group established by the Gowins.

The healthcare fraud conviction resulted from Dennis and Cheryl Gowins’ failure to disclose Dennis’ previous felony conviction on multiple applications related to employment, enrollment, and credentialing with several employers and heath care entities.

These false statements enabled Dennis Gowin to become a licensed professional counselor in Virginia, obtain employment and for the Gowins to receive payment for health insurance providers, including Virginia Medicaid.

The conviction for wrongful disclosure of individually identifiable healthcare information resulted from the Gowins’ removal of over 100 patient files from Hope for Tomorrow without permission from Hope for Tomorrow or the individual patients.

These files were returned to Hope for Tomorrow after being discovered during the execution of a federal search warrant at the Gowins’ residence.

The investigation of the case was conducted by the Office of the Virginia Attorney General – Medicaid Fraud Control Unit, United States Department of Health and Human Services – Office of Inspector General, Virginia State Police and the United States Postal Inspection Service. Assistant United States Attorney Ronald M. Huber prosecuted the case for the United States.

SourceURL: https://www.app.com/story/news/2018/12/06/lakewood-nj-fraud-guilty-restitution-medicaid-food-stamps/2205497002/

Lakewood fraud: A $53,418.39 check to the state and another guilty plea

Stacey Barchenger, Asbury Park Press Published 4:46 p.m. ET Dec. 6, 2018 | Updated 5:29 p.m. ET Dec. 6, 2018

Moshe Hirschmann of Lakewood pleaded guilty Thursday to welfare benefits theft in Ocean County Superior Court. Brian Johnston, Asbury Park Press

Moshe Hirschmann of Lakewood, pleads guilty to welfare benefits theft on Thursday in Ocean County Superior Court.(Photo: Brian Johnston)

TOMS RIVER - A fifth person charged in early morning raids in Lakewood last year has pleaded guilty to theft of government benefits, paying $53,418.39 in restitution as part of a sentence that will allow him to avoid a permanent conviction.

Moshe Hirschmann, 31, pleaded guilty to a third-degree count of theft by deception on Thursday, one day after four others charged in the raids accepted similar plea deals in the case.

LAKEWOOD FRAUD: 4 guilty of theft, tax crimes following 2017 raids

Hirschmann admitted that between January 2009 and December 2015 he under-reported his income so he could receive Medicaid and food stamp benefits. Assistant Ocean County Prosecutor Christopher Heisler said Hirschmann will go into a pretrial intervention program in exchange for repaying all the benefits he stole.

“The defendant did come prepared to pay that restitution today, in full,” Heisler told Superior Court Judge Wendel E. Daniels.

Pretrial intervention is a probation-like program offered to first-time, low-level offenders that typically lasts one year. If a person completes all of its terms, the charge against them is dismissed, and it can be expunged.

The only other condition of Hirschmann's pretrial intervention program is that he pay $125 in fees, Daniels said in court.

“Can you comply with those conditions?” the judge asked.

“Yes, your honor,” Hirschmann replied.

Hirschmann will not serve jail time unless he violates the rules of the pretrial intervention program. An Asbury Park Press analysis of conviction records shows that statewide, the majority of people convicted of theft by deception don’t receive sentences of jail time.

Hirschman was arrested in law enforcement raids at 13 homes in Lakewood. His wife, Nechama, was also arrested. However, Hirschmann said Thursday he was solely responsible for the theft and the prosecutor dismissed the charges against Nechama Hirschmann.

On Wednesday, four other men pleaded guilty to under-reporting their incomes to receive government assistance benefits, marking the first resolutions since the arrests of 26 people that changed the tenor in Lakewood. The raids prompted thousands of people to drop their Medicaid benefits and led to public education efforts about who qualified for government aid. Of the 26 cases, 16 are still open.

MEDICAID FRAUD: Lakewood board member repays half owed in amnesty deal, builds $500K house

$2.6M never repaid because of amnesty deals

Amnesty program could trip up nominee for judge

Ocean County Superior Court Judge Wendel Daniels questions Moshe Hirschmann on Thursday during a 11-minute hearing in which Hirshmann pleaded guilty to theft of Medicaid and food stamp benefits. (Photo: Brian Johnston)

Citing a more widespread problem in Ocean County, New Jersey Comptroller Philip J. Degnan's office then offered an amnesty deal, allowing others to avoid criminal prosecution if they came forward and repaid what they stole. The confidential, and controversial, program recovered less than half of the money it was intended to and is the focus of an ongoing lawsuit against the state.

For Hirschmann, it took just 11 minutes in court Thursday to resolve the case that has lingered for 18 months.

Leaving the courtroom, his attorney, Daniel J. Holzapfel, said the outcome was a “great result.”

“He’s a good person,” Holzapfel said of his client.

First Lakewood Welfare Fraud cases settled

Fullscreen

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Eliezer Sorotzkin, Tzvi Braun, Samuel Serhofer, and Yisroel Merkin wait for the start of court. The first four plea deals in the Lakewood Welfare Fraud cases were settled in front of Judge Wendel Daniels in Ocean County Court in Toms River on December 5, 2018. Twenty Six people were arrested in the raids in 2017. Peter Ackerman

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SourceURL: https://newpittsburghcourieronline.com/2018/12/05/things-will-be-handled-decent-and-in-order-arlinda-moriarty-proclaims-innocence-against-medicaid-fraud-charges/

‘Things will be handled decent and in order’—Arlinda Moriarty proclaims innocence against Medicaid fraud charges

Christian Morrow and Rob Taylor Jr., Courier Staff Writers

ARLINDA MORIARTY

The lawyer for Arlinda Moriarty made it clear to the New Pittsburgh Courier his client's position—not guilty.

"Arlinda has pled 'not guilty' and she will explain her position at trial," Attorney Kerry Lewis told the New Pittsburgh Courier, Dec. 3. "And her position is that she is not guilty of any of the alleged criminal acts and did not willfully or knowingly commit those acts."

Between January 2011 and April 2017, Moriarty Consultants and three related companies that provide in-home Medicaid services received more than $87 million for service-related claims it submitted to the federal government.

> *"Arlinda has pled 'not guilty' and she will explain her position at trial. And her position is that she is not guilty of any of the alleged criminal acts and did not willfully or knowingly commit those acts."*
> *KERRY LEWIS*
>
> *Attorney for Arlinda Moriarty*
>
> *Share*

Last week, a federal grand jury released a 22-count indictment charging that part of that money was fraudulently obtained through a conspiracy among company heads Arlinda Moriarty, her sister Daynelle Dickens and 10 of their former employees.

ARLINDA MORIARTY

Lewis told the Courier he is still reviewing information in the indictment and awaiting the U.S. Attorney's discovery material.

"You saw the indictment—it's 36 pages. So there's quite a bit," he said. "In fact the U.S. Attorney described it as a 'boatload' of material."

What's in that boatload, said U.S. Attorney for the Western District of Pennsylvania Scott Brady, is evidence gathered by the FBI, the U.S. Postal Service, U.S. Department of Health & Human Services, the IRS and the Pennsylvania attorney general's office that outlines a "family crime conspiracy."

"In terms of the scope of the fraud, the number of participants charged, the timeframe, and the amount of loss, it really is an incredibly significant case," he told KDKA-TV last week.

Along with Moriarty and Dickens, the others charged with fraud were either employees of Moriarty Consultants or three other companies controlled by the sisters: Activity Daily Living Services; Coordination Care; and Everyday People Staffing. They include: Julie Wilson, Tamika Adams, Tony Brown, Terry Adams, Terra Dean, Tionne Street, Keith Scoggins and Larita Walls, all residing in and around Pittsburgh, along with Tia Collins, a resident of South Carolina, and Luis Columbie-Abrew, a resident of Georgia.

Moriarty, Dickens, Wilson and Tamika Adams are also charged with one count of concealing material facts in relation to a health care matter. In addition, Moriarty, Tamika Adams and Columbie-Abrew each are charged with multiple counts of aggravated identity theft.

Ex-employees Travis Moriarty, Tiffhany Covington, Brenda Lowry and Autumn Brown were indicted separately in October. This past Monday, Dec. 3, in court, Travis Moriarty admitted to a conspiracy count.

By admitting to the conspiracy count, Travis Moriarty, in effect, admitted to fabricating timesheets for in-home services that were never provided, along with preparing false documents.

Brady’s office went further, saying fraud was committed through a variety of schemes. Among these were filing false claims for medical and transportation services that were never rendered; submitting timesheets for employees who did not exist, or for employees who were working other jobs or on vacations at the time; improperly using consumers’ personal identifying information; and billing for in-home services for individuals who were actually hospitalized, incarcerated, or deceased.

ARLINDA MORIARTY DAY—This photo, taken January 10, 2017, shows Arlinda Moriarty holding her proclamation from the City of Pittsburgh, surrounded by friends, family and elected officials. (Photo by Diane I. Daniels)

In a conspiracy case, Lewis said, the evidence against one defendant can be used to make a case against another.

"But to do that, you have to prove a conspiracy first. There are instances in large companies where people underneath are doing things that are unknown to the director," he said.

Arlinda Moriarty spoke with the New Pittsburgh Courier in an exclusive interview, Tuesday, Dec. 4. The proud Garfield native, who graduated from Peabody High School in 1988 and later received her collegiate degree from Robert Morris University, said that although she could say many things, only one sentence needed to be said: "Things will be handled decent and in order," Arlinda Moriarty said, citing a scripture from 1st Corinthians.

Arlinda Moriarty's office sits on Perrysville Avenue on the North Side, a woman so regarded that the City of Pittsburgh proclaimed Jan. 10, 2017 "Arlinda Moriarty Day." She was handed a proclamation at City Hall, complete with family and friends in attendance.

Courier reporter Diane I. Daniels interviewed Arlinda Moriarty just after she received the proclamation last year. Daniels reported that Arlinda Moriarty, who grew up in the Garfield Heights housing projects and was diagnosed as an adult with Attention Deficit Hyper Disorder, never would take a backseat to success.

"I never let that or where I grew up define me," Arlinda Moriarty told Daniels.

"The bottom line is Arlinda is wonderful person who's done a lot for a lot of people," added Arlinda Moriarty's lawyer, Lewis. "She's a real advocate for Attention Deficit Disorder, which she suffers from. She's never had any problems with the law. She's just a good woman, and that's self-evident to anyone who meets her."

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SourceURL: https://www.rockdalenewtoncitizen.com/doctor-and-offices-to-pay-to-resolve-allegations-of-false/article_2ab0a419-8e2c-5119-a81e-38f1cf406238.html

Doctor and offices to pay $213,000 to resolve allegations of false claims

ATLANTA – Anil J. Desai, M.D., East Metro Internal Medicine, L.L.C. and Rockdale-Newton Hematology-Oncology (the "Desai Parties"), based in Conyers and Covington, have agreed to pay $213,000 to resolve allegations that they violated the False Claims Act by submitting claims to Medicare and Medicaid for drugs that were never provided to their patients, and for drugs that had not received final marketing approval by the U.S. Food and Drug Administration ("FDA").

This case was investigated by the U.S. Attorney's Office for the Northern District of Georgia, the U.S. Department of Health and Human Services - Office of Inspector General, and the Food and Drug Administration – Office of Criminal Investigations.

"When healthcare providers bill for goods and services that they did not provide, it is the equivalent of taking money from the taxpayer's pocket," said U.S. Attorney Byung J. "BJay" Pak. "Additionally, billing for medications that were never approved by the FDA puts patients at risk. We will continue to pursue healthcare providers who put their own bottom line ahead of patient care."

"The Office of Inspector General will diligently investigate providers who seek to defraud the Medicare and Medicaid trust funds through nefarious billing practices," said Derrick L. Jackson, Special Agent in Charge at the U.S. Department of Health and Human Services, Office of Inspector General in Atlanta. "This investigation illustrates how we collaborate with our law enforcement partners to protect beneficiaries while holding suspicious providers accountable."

"FDA's drug approval requirements are designed to ensure the safety, efficacy, and quality of drugs distributed or administered to American patients," said H. Peter Kuehl, Acting Special Agent in Charge, FDA Office of Criminal Investigations' Miami Field Office. "Today's announcement should serve as a reminder of our continued focus on those that risk patients' health for profit."

"Our Medicaid Fraud Control Division is always at work for Georgians, ensuring that Medicaid providers who bill the Medicaid program do not abuse it for their own financial gain," said Georgia Attorney General Chris Carr. "We greatly appreciate the partnerships we have with federal agencies who share this same mission, and we will continue supporting them to prevent fraudulent activity."

Dr. Desai owns both East Metro Internal Medicine, L.L.C. ("East Metro") and Rockdale-Newton Hematology-Oncology ("Rockdale-Newton"), through which he has provided treatment to cancer patients. The Desai Parties billed Medicare and Medicaid for the drugs Eloxitan and Procrit in connection with Dr. Desai's treatment of cancer patients. Eloxitan is a chemotherapy drug used to treat certain types of cancer and Procit is a medication that is used to treat anemia caused by chemotherapy as well as other conditions.

The government alleges that between Nov. 1, 2008 and Aug. 13, 2012, the Desai Parties submitted claims to Medicare and Medicaid for Procrit even though there was no record that they purchased enough Procrit to cover the amount that they billed. Moreover, the Government alleges that during that same time period, the Desai Parties submitted claims to Medicare and Medicaid for Eloxitan that had been purchased from a Canadian company, Quality Specialty Products, and had not received final marketing approval by the FDA. The civil settlement resolves the government's investigation into these allegations.

This case was investigated by the U.S. Attorney's Office for the Northern District of Georgia, the U.S. Department of Health and Human Services - Office of Inspector General, and the Food and Drug Administration – Office of Criminal Investigations.

The civil settlement was reached by Assistant U.S. Attorney Neeli Ben-David, Deputy Chief of the Civil Division, and Sara Vann, Assistant Attorney General with the Georgia Medicaid Fraud Control Unit.

For further information please contact the U.S. Attorney's Public Affairs Office at USAGAN.PressEmails@usdoj.gov or (404) 581-6016. The Internet address for the U.S. Attorney's Office for the Northern District of Georgia is http://www.justice.gov/usao-ndga.

Cheyenne Couple Gets 37 Months for Health Care Fraud

December 4, 2018

Thinkstock

A Cheyenne psychologist and his wife have been sentenced to 37 months in federal prison for making false statements as part of a scheme to fraudulently bill Wyoming Medicaid for mental health services, which were never provided.

John Robert Sink, Jr., 68, and Diane Marie Sink, 63, were indicted in March 2018 by a federal grand jury for health care fraud, making false statements and money laundering.

The U.S. Attorney's Office says the two submitted bills to Wyoming Medicaid for $6.2 million in alleged group therapy between February 2012 and December 2016, but the bills were false and fraudulent because the services provided didn't meet Wyoming Medicaid's definition of group therapy.

The Sinks also falsely billed Medicaid for beneficiaries who were not participating in any activities, and therefore didn't receive any of the claimed mental health services.

When Wyoming Medicaid audited the Sinks in May 2016, the Sinks didn't have necessary documentation to support their billing, so they ordered an employee to create backdated treatment plans.

The couple then submitted these phony treatment plans to Wyoming Medicaid to justify the false group therapy bills and to cover up their fraudulent billing scheme.

Each pleaded guilty to one count of making false statements in relation to health care as part of a plea agreement. In exchange, prosecutors dismissed the other counts in the indictment.

In addition to prison, the Sinks were also ordered to pay over $6.2 million in restitution and to forfeit over $750,000 in assets traceable to the fraud.

SourceURL: https://homehealthcarenews.com/2018/12/home-health-investigations-help-oig-recover-2-91-billion-in-2018/

Home Health Investigations Help OIG Recover $2.91 Billion in 2018

By Bailey Bryant | December 4, 2018

For years, the Department of Health and Human Services Office of Inspector General (OIG) has been ramping up efforts to battle Medicare fraud — including in home health and hospice. Now, a new OIG semiannual report is showing the agency's progress, to the tune of $2.91 billion in expected investigative recoveries for fiscal year 2018.

Throughout 2018, OIG has repeatedly said it's ramping up its oversight because fraud and improper billing cost the government hundreds of millions of dollars each year, even testifying to Congress on how to combat Medicare and Medicaid fraud and overpayments.

In the past several years, home health agencies have been top targets. In 2016, OIG flagged 500 home health agencies and 4,500 physicians for using suspicious practices. And earlier this year, OIG called out the hospice industry, identifying vulnerabilities in the Medicare Hospice Program and keeping an eye out for illicit marketing maneuvers and unlawful physician kickback arrangements.

"Increasingly, we're uncovering fraud schemes that are quite concerning," Jodi Nudelman, regional inspector general for OIG, told HHCN in August. "Particularly when beneficiaries are just unaware that they're even being enrolled in hospice."

In fiscal year 2018, investigations resulted in criminal actions against 764 individuals or entities and civil actions against 813. More than half of those — 305 criminal and 449 civil actions — and $1.4 billion in investigative receivables came between April 1 and September 30, the period for which the semiannual report covers.

While fraud recovery amounts aren't broken down by category, Medicaid fraud was identified as a top priority area for OIG, according to the report.

Litigation against a home care company out of Virginia serves as an example detailed in the report.

Hope In-Home Care, LLC, which was accused of submitting false claims to the Virginia Medicaid Program, agreed to pay $3.3 million in a settlement to resolve allegations of fraud from January 1, 2011 to September 30, 2013.

Hope submitted claims for uncertified personal care aides, billed for services that were never performed, falsified documents and claims, among other allegations, according to the report.

The settlement is just one of many victories for OIG during the semiannual report period, which helped contribute to more than $1 billion in aforementioned investigative recoveries.

In addition, the OIG report shed some light on how the agency targets investigations, specifically outlining the important role that tips play in fraud detection.

Hotline complaints and online fraud reporting helped OIG recover $27 million over a six-month period, according to the semiannual report.

HHS' OIG hotline received 60,390 calls between April 1 and September 30, resulting in 3,051 tips the office recommended for action, the report says. Meanwhile, it also detailed that 3,618 tips referred for action came through OIG's website, while 1,300 came through letters or faxes. Additionally, 227 useful tips came via other avenues, according to the report.

Written by Bailey Bryant

Bailey Bryant

Reporter at Home Health Care News

When she's not reporting, Bailey likes exploring Chicago for brunch spots and work out classes. Previously, she worked in book and magazine publishing before becoming a tv reporter.

SourceURL: https://atlantablackstar.com/2018/12/04/self-proclaimed-money-maker-alexis-skyys-medicaid-confession-draws-mixed-reactions-from-lhh-viewers/

Self-Proclaimed ‘Money Maker’ Alexis Skyy’s Medicaid ‘Confession’ Draws Mixed Reactions from ‘LHH’ Viewers

December 4, 2018

“**Love and Hip Hop**” fans were slightly confused after co-star **Alexis Skyy** discussed her Medicaid assistance.

Skyy gave birth to her daughter Alaiya Grace in March. The baby was born prematurely by arriving three months early and was diagnosed with hydrocephalus, which is a buildup of fluid in the cavities deep within the brain.

(photo credit: @alexisskyy)

During the latest episode of “LHH,” Skyy explained that her 8-month-old daughter has had multiple surgeries and treatments for her medical condition. While conversing with her grandmother on the show, the 23-year-old mother slipped up and said, “I’ve been working so much and missing appointments for her [Alaiya]. … I gotta get everything switched over for she could get her treatments and stuff because I didn't know moving up here [to New York] they wasn't going to accept her Medicaid."

"LHH" viewers — seemingly missing the fact that Skyy said her child is the one on Medicaid — were scratching their heads as to how Skyy could be on Medicaid when she's securing the "money" bag and sporting a "$3000 Louis Vutton bag."

"So who's gonna tell Alexis that her Medicaid has income requirements ? As a self proclaimed 'money maker' she may be ineligible. #LHHNY."

"I would love to see her at a doctors appointment with her fur coat and Louis Vuitton bag and present her Medicaid card…. Sis dig in that $3000 bag and pay that 40 copay. FOH!!! Report Medicaid Fraud yall, Alexis breaking the law."

"Currently trying to figure out how I can report Alexis Skyy for Medicaid fraud. Because bitch if I don't qualify neither do you ."

"So correct me if I'm wrong, but Alexis Skyy on this here tv talking about she has all this money and wearing these expensive looking wigs but also said jersey won't accept her child's Medicaid……I'm confusion isn't Medicaid specifically for low income families?"

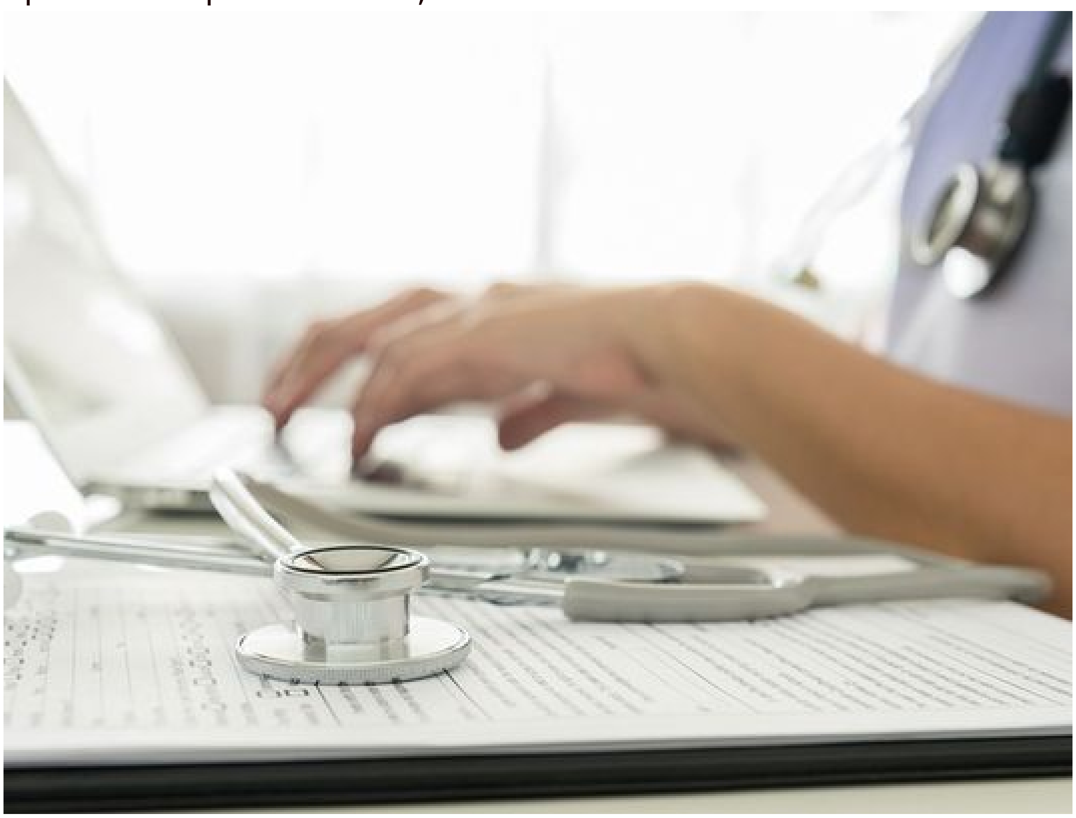
"How in the hell does Alexis Skyy have this baby on Medicaid ? When she's walking around with the latest Chanel bags and furs on! Make it make sense!"

Skyy is in the process of trying to convince her former boyfriend rapper **Fetty Wap**, who she believes is the father of her child, to take a paternity test.

Medicaid is a state and federal program of health care coverage for low-income people, including eligible adults, children, pregnant women, elderly adults and people with disabilities. As a child born with a special health need, Alaiya Grace likely would qualify for Medicaid assistance because of her disability and regardless of whether the designer props her mother sports on "LHH" make any statement about her actual family income.

TennCare seeks $18 million from bankrupt community health clinic, alleging fraud

Anita Wadhwani, Nashville Tennessean Published 4:01 p.m. CT Dec. 4, 2018 | Updated 3:10 p.m. CT Dec. 5, 2018



Officials at a Franklin-based health care clinic that filed for bankruptcy in August repeatedly over-billed TennCare for patient visits then lied to state officials about it, according a filing in bankruptcy court seeking $18 million in payments and penalties.(Photo: utah778/Getty Images/iStockphoto)

Correction: The story has been updated to reflect that Prohealth Rural Health Services is a type of federally qualified community health center. State officials incorrectly described its designation.

Officials at a Franklin-based health care clinic that filed for bankruptcy in August repeatedly over-billed TennCare for patient visits then lied to state officials about it, according a filing in bankruptcy court seeking $18 million in payments and penalties.

Prohealth Rural Health Services operates clinics in Franklin and Columbia, serving patients in 16 surrounding counties. It is a type of federally qualified community health centers that allows it to earn higher payments in exchange for seeing patients in under-served communities.

But Prohealth abused that status to rake in millions in unearned payments from the state's Medicaid program for more than five years, the filing by lawyers for TennCare alleges.

Dr. Ray White, the clinics' chief executive officer, knowingly participated in the scheme, which involved using a software system to consistently overstate the number of patient visits, the filing said.

Clinic employees issued multiple internal warnings about the system. Despite those warnings, the clinics' operators sent the inflated patient data to the Comptroller's office.

White and other unnamed clinic operators "intended to deceive the Comptroller and TennCare," the filing said. They also intentionally concealed their fraud by "ordering subordinate employees to use incorrect data sources or to manipulate data."

An attorney for Dr. White called the allegations "ridiculous."

"Dr. White adamantly denies that there was any fraud," said John Williams, the attorney. "I think that’s just a ridiculous allegation for TennCare to make. I think it singles (Dr. White) out in an unfair manner, and he certainly denies on behalf of his company and himself individually that he did anything wrong."

Higher rates for rural health clinics

Federally qualified community health centers in Tennessee operate under the oversight of the Comptroller. They have a complicated payment model because they can charge higher rates than other health care providers seeing TennCare patients.

These providers are reimbursed by TennCare's managed care organizations for the services they provide. They then submit bills to the Comptroller for the difference in the managed care rate and their higher rates. The Comptroller turns over those bills to TennCare for payment.

It is those "wrap-around" payments that TennCare accuses Prohealth of fraudulently submitting.

Prohealth's two clinics provide primary health care, dental services and addiction treatment, according to their website.

The nonprofit listed $2.8 million in liabilities when it filed bankruptcy, which does not include the $18 million TennCare seeks.

Phone calls seeking comment to the two clinics went unanswered Tuesday.

More than 430,000 Tennesseans use community health centers across the state.

More: 5 things to know about Tennessee's rural hospitals

More: Williamson County leads state in cash shortages because of employee thefts

SourceURL: https://www.csindy.com/coloradosprings/el-paso-county-pathologist-pleads-guilty-to-fleecing-more-than-1-million-from-medicaid/Content?oid=17527329

El Paso County Pathologist pleads guilty to fleecing more than $1 million from Medicaid

By Faith Miller
click to enlarge

A former speech pathologist in El Paso County pleaded guilty to fraudulently billing Medicaid more than $1 million, the state attorney general's office announced Nov. 29.

Tara Rose, of Beyond Words LLC, was sentenced to eight years in Colorado Community Corrections and 10 years of probation on felony theft charges. She was also ordered to pay $1.28 million in restitution to the Colorado Department of Health Care Policy and Financing.

Rose received Medicaid funds for children's treatment sessions "that did not occur, and many of those patients had no relationship with Rose and had no idea who she was," according to a statement from the attorney general's office. She also billed Medicaid for treatments that were more frequent and extensive than those she actually provided.

"Medicaid fraud steals from Colorado taxpayers and diverts limited healthcare resources from the most vulnerable citizens of our state," Attorney General Cynthia Coffman is quoted in the statement. "My office will continue to aggressively prosecute any health care provider who engages in this type of criminal activity."

South Texas doctor sentenced to five years in prison for role in a fraudulent medical clinic

November 29, 2018, Washington DC—A Houston, Texas doctor was sentenced to 60 months in prison followed by three years of supervised release today for his role in a fraudulent medical clinic that ran costly, unnecessary diagnostic tests.

Assistant Attorney General Brian A. Benczkowski of the Justice Department's Criminal Division, US Attorney Ryan K. Patrick of the Southern District of Texas, Special Agent in Charge Perrye K. Turner of the FBI's Houston Field Office, Special Agent in Charge C.J. Porter of the Department of Health and Human Services Office of the Inspector General's (HHS-OIG) Dallas Regional Office and the Texas Attorney General's Medicaid Fraud Control Unit (MFCU) made the announcement.

Faiz Ahmed, MD, 66, of Houston, was sentenced by US District Judge Gray H. Miller of the Southern District of Texas. Judge Miller also ordered the defendant to pay $4,192,156 in restitution. Ahmed was found guilty following a six-day trial in 2017 of one count of conspiracy to commit health-care fraud and seven counts of health-care fraud.

Ahmed and eight co-defendants engaged in a conspiracy to falsely bill Medicare and Medicaid for medically unnecessary diagnostic tests. According to evidence admitted at trial, Ahmed agreed to approve the unnecessary testing and allowed his physician number to be used to fraudulently bill the Medicare program. As a result of the overall conspiracy, Medicare and Medicaid were billed approximately $13 million and paid out approximately $9 million in false claims.

Eight others have pleaded guilty for their respective roles including Mkrtich Yepremian, 61; Bompa Mbokoso Mompiere, 59; Michael Wayne Wilson, 49; Jermaine Doleman, 41; Harding Dudley Ross, 64; Eric Johnson, 64; Ann Marie

Rocha, 51; and Eddie Wayne Taylor, 59, all of Houston. These defendants have all been sentenced.

This case was investigated by the FBI, HHS-OIG and the Texas Attorney General's Medicaid Fraud Control Unit. Trial Attorney Jason Knutson of the Criminal Division's Fraud Section and Special Assistant US Attorney Suzanne Bradley formerly of the Southern District of Texas prosecuted the case.

The Criminal Division's Fraud Section leads the Medicare Fraud Strike Force. Since its inception in March 2007, the Medicare Fraud Strike Force, which maintains 14 strike forces operating in 23 districts, has charged nearly 4,000 defendants who have collectively billed the Medicare program for more than 14 billion.

SourceURL: https://www.allongeorgia.com/georgia-state-news/medical-tech-company-agrees-to-pay-1-87m-to-resolve-false-claim-allegations-arising-from-improper-kickback-payments/

Medical tech company agrees to pay $1.87M to resolve false claim allegations arising from improper kickback payments

By

AllOnGeorgia

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December 5, 2018

Picture credit - Business Ethics

A global medical technology company has agreed to pay Georgia and the federal government to resolve false claims for improper kickback payments to physicians.

LivaNova USA, Inc. ("LivaNova"), formerly known as Cyberonics, Inc., has agreed to pay the United States and the State of Georgia $1.87 million to resolve allegations that it violated the False Claims Act and the Georgia False Medicaid Claims Act by knowingly paying kickbacks to Georgia physicians with the intent to cause referrals for implantation of LivaNova's medical devices.

"Healthcare providers must make recommendations about their patients' health without respect to their own financial interests and medical device manufacturers cannot be permitted to influence that process with thinly-disguised kickback payments," said U.S. Attorney Byung J. "BJay" Pak. "This settlement demonstrates our commitment to ensuring that the healthcare provided to our citizens, and the medical guidance given by Georgia physicians, is free from improper monetary influence."

"The success of Georgia's Medicaid program depends on the integrity of medical professionals in making decisions regarding patient care," said Attorney General Chris Carr. "When companies provide incentives to physicians that emphasize interests beyond the patient, the entire system is corrupted. I am proud of our Medicaid Fraud Division's work on this case, and we will continue to work alongside our federal partners to root out this activity."

The government's investigation concerned LivaNova's policy and practice of paying speaking fees to Georgia physicians for supposed speaking and marketing events at which the attendees were primarily the physicians and their own staff.

The physicians who received these fees were amongst the highest referral sources for surgical implantation of LivaNova's device for treatment of refractory epilepsy. The government alleges that these payments violated the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), which prohibits the knowing and willful payment of "remuneration" to induce or reward the generation of business involving any item or service payable by Medicare and Medicaid. Such violations are actionable under the False Claims Act and the Georgia False Medicaid Claims Act.

The settlement resolves allegations filed by Ashley Case, a former employee of LivaNova, under the *qui tam*, or whistleblower, provisions of the False Claims Act. Under the Act, private citizens can bring suit on behalf of the government for false claims and share in any recovery.

The False Claims Act also permits the government to intervene in such lawsuits, as it did in this case. The lawsuit was filed in the Northern District of Georgia and is captioned *United States of America and State of Georgia ex rel. Ashley Case v. LivaNova, P.L.C.,* Civil Action No: 1:16-cv-0807-MHC (N.D. Ga.). Ms. Case will receive a share of the settlement.

The claims resolved by the settlement are allegations only, and there has been no determination of liability.

This matter was investigated by the U.S. Attorney's Office for the Northern District of Georgia and the Georgia Medicaid Fraud Control Unit.

Assistant U.S. Attorney Gabriel Mendel handled this matter for the U.S. Attorney's Office.

SourceURL: https://www.dispatch.com/news/20181206/mansfield-drug-treatment-center-owes-state-11-million-audit-finds

Mansfield drug treatment center owes state $11 million, audit finds

By Catherine Candisky
The Columbus Dispatch
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Posted Dec 6, 2018 at 3:25 PM Updated Dec 6, 2018 at 6:46 PM

A addiction-treatment program in Mansfield owes nearly $11 million to Ohio's tax-funded Medicaid program for services that it failed to substantiate or that were not eligible for reimbursement, a state audit found.

A review of Medicaid claims submitted by the Mansfield Urban Minority Alcoholism and Drug Abuse Outreach Program found a number of violations that should have disqualified the treatment program from receiving $10 million of the $18.7 million it was paid in 2014 and 2015.

Auditor Dave Yost said the overpayment was the largest amount reported in a Medicaid review since he took office in 2011. With interest, the not-for-profit treatment program owes the state nearly $11 million.

"Despite overwhelming circumstances, Ohio's addiction-treatment programs have helped lead the charge on the front lines of the state's opioid crisis," Yost said. "As their work continues, I urge these providers to hold fast to the safeguards that protect the state's Medicaid resources and the citizens who depend on them."

The $25 billion Medicaid program provides health coverage to 3 million poor and disabled Ohioans.

In response to the audit, the treatment center's attorney, Timothy G. Pepper, stressed that there was no "fraud, waste or abuse" and all services questioned were provided to patients. He attributed the problems to an increase in patients as a result of the state's 2014 expansion of Medicaid and the program's transition to an electronic record-keeping system.

Auditors found that the company lacked records to support reimbursements for 41 percent of lab services, 26 percent of counseling services, 25 percent of outpatient services and 12 percent of medication services.

An inspection of the company's personnel records found 29 services provided by unqualified staff members because they failed to meet Medicaid requirements.

For instance, employees lacked required licenses or certification from the Ohio Board of Nursing and Ohio State Medical Board.

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The audit also uncovered 262 services provided without required patient-treatment plans authorizing the services. An additional 15 services had patient-treatment plans, but they did not authorize the services provided.

The Mansfield center also billed Medicaid or services provided by partner organizations in Elyria and Dayton without reporting them to the Department of Medicaid as required, auditors found.

Since 2011, Yost's office has uncovered $50 million in improper payments to Medicaid providers.

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