Medicaid FWA Curator: Volume 7

Notebook:	Curator: FWA		
Created:	2/11/2019 4:03 PM	**Updated:**	2/14/2019 8:58 AM
Tags:	8-Fraud, Roundup		
URL:	http://www.wcbe.org/post/operators-local-substance-abuse-treatment-facility-indicte...		

consulting | training | free webinars

clay@mostlymedicaid.com | 919-727-9231

Medicaid Fraud Curator

Week of Feb 11th , 2019

Total this week: $90M+

Operators Of Local Substance Abuse Treatment Facility Indicted For Medicaid Fraud

SourceURL: http://www.wcbe.org/post/operators-local-substance-abuse-treatment-facility-indicted-medicaid-fraud

Operators Of Local Substance Abuse Treatment Facility Indicted For Medicaid Fraud

Operators Of Local Substance Abuse Treatment Facility Indicted For Medicaid Fraud

By Associated Press • Feb 9, 2019

Ryan Sheridan

Credit wytv.com

Federal authorities say six people have been indicted in a 48 million dollar Medicaid fraud scheme.

Thirty-eight-year-old Ryan Sheridan and five others were charged this week with conspiracy to commit health care fraud related to drug and alcohol recovery centers in Austintown Township and Whitehall. Prosecutors say Sheridan is sole owner of Braking Point Recovery Services, which has been accused of charging

Medicaid millions for services that weren't provided, weren't medically necessary or lacked proper documentation. The government seeks 3 million dollars in forfeited property, including Sheridan's replicas of vehicles from popular films.

6 face charges in $31M Medicaid fraud case

SourceURL: https://www.vindy.com/news/2019/feb/08/ohio-six-face-charges-in-m-medicaid-frau/

6 face charges in $31M Medicaid fraud case

By Justin Dennis | February 8, 2019 at 12:07a.m.

By Justin Dennis

jdennis@vindy.com

CLEVELAND

A 60-count federal indictment alleges a recovery home owner handed out opioids indiscriminately while raking in $31 million in fraudulent Medicaid claims.

Ryan P. Sheridan, 38, of Leetonia, the former owner of Braking Point Recovery Center, and five Braking Point workers face charges including conspiracy to commit health care fraud, health care fraud, money laundering, operating a drug

premises, conspiracy to distribute controlled substances and improper use of drug distributor registrations, according to a release from Justin Herdman, U.S. Attorney for the Northern District of Ohio.

Braking Point operated state-licensed drug and alcohol rehabilitation centers in Austintown and Whitehall, a Columbus suburb.

Also named in the indictment are Jennifer M. Sheridan, 40, of Austintown, Sheridan's ex-wife and Braking Point's medical records and billing coordinator; Kortney L. Gherardi, 29, of Girard, and Lisa M. Pertee, 50, of Sunbury, near Columbus, both of whom oversaw day-to-day operations at the facilities; and Thomas Bailey, 44, of Poland, and Arthur H. Smith, 54, of Austintown, both of whom were the center's state-licensed physicians.

According to the 38-page indictment, Braking Point submitted about 134,744 fraudulent Medicaid claims totaling more than $48.5 million between May 2015 and September 2017, of which Medicaid paid about $31.1 million.

The indictment alleges the bills were inflated, didn't correspond to proper Medicaid codes or were for patients who didn't have a physician's diagnosis or drug purchases made without proper Drug Enforcement Agency authorization, among other violations.

The Ohio Department of Medicaid suspended payments to Braking Point in October 2017, around the same time federal agents raided several of Sheridan's area properties.

In 2017, Bailey is alleged to have used Smith's DEA registration to dispense more than 3,000 doses of Suboxone, an opioid medication used to treat withdrawal symptoms. Sheridan continued to use the registration belonging to another, unnamed center doctor for five months after that doctor resigned in April 2017, purchasing more than 8,000 dosage units of various opioid medications from Austintown pharmacies.

The defendants didn't establish individualized treatment plans for each patient, as required by law – and Smith was rarely at the facility to determine whether they actually needed Suboxone – "instead every patient entering detox was given the standard protocol of Suboxone and same medical treatment," the indictment states.

According to the indictment, Sheridan paid for patients' rent at area sober homes, provided they continued to return to Braking Point for treatment "and, if the patients did not, Braking Point would no longer pay the patients' rent at that sober home."

"Treatment for people struggling with drug and alcohol addiction is vitally important, but these defendants profited off the suffering of others," Herdman said in the release.

The indictment alleges Sheridan laundered more than $6.2 million in Braking Point proceeds, which he used in investments, property deals including his $792,000 Leetonia home and various vanity items such as a $158,000 "Batmobile" vehicle, a $140,000 Cadillac hearse popularized by the "Ghostbusters" franchise and a $58,000 replica of the DeLorean from "Back to the Future."

The indictment seeks forfeiture of about $2.6 million in account funds and cash seized during the 2017 raids.

"While the vast majority of the health care professionals in this country are committed to saving lives, there are a few who are merely drug dealers hiding in plain view, and driven by greed," DEA Special Agent in Charge Timothy J. Plancon said in the release.

Authorities did not specify the length of the investigation into Sheridan and Braking Point, but Mike Tobin, spokesman for federal prosecutors, said it predates the facility's October 2017 closure.

FBI Special Agent Vicki Anderson declined to comment on the investigation, as to not harm Sheridan's prosecution, and the search warrants executed at Sheridan's properties in 2017, which are still sealed.

Sheridan also faces 14 felony counts and a single misdemeanor count of drug possession in Columbiana County court. Investigators found large quantities of anabolic steroids and stimulants such as cocaine and amphetamines during the October raid of Sheridan's Leetonia home.

That case is set for a jury trial May 6.

Two found guilty in major Minnesota Medicaid fraud case

SourceURL: http://www.startribune.com/two-found-guilty-in-major-minnesota-medicaid-fraud-case/505596752/

Two found guilty in major Minnesota Medicaid fraud case

Two Minneapolis women have been convicted of operating fraudulent personal care attendant agencies as part of the largest Medicaid fraud case in Minnesota history.

Hennepin County District Judge Jay Quam found that Lillian Richardson, 54, and Bridgett Burrell, 56, defrauded the state's Medicaid program of $7.7 million meant for disabled people who need help with daily living tasks, state Attorney General Keith Ellison said in a news release Friday night.

"It's shameful that these defendants illegally set up home care companies that were supposed to help people solely for the purpose of lining their own pockets," Ellison said. "They took advantage of vulnerable people, sullied the honest work

that hardworking personal care attendants do every day, and defrauded the people of Minnesota."

Richardson and Burrell were found guilty of one count each of racketeering and eight counts each of aiding and abetting theft by swindle of a value greater than $35,000.

In July 2017, former Attorney General Lori Swanson announced that charges had been filed against seven people, including Richardson and Burrell, in relation to the complex Medicaid fraud scheme. Since then, all five of Richardson and Burrell's co-defendants have pleaded guilty, and six others have been charged. The case against Richardson and Burrell has been the only one to go to trial.

Despite telling a court when she was first convicted of Medicaid fraud in 2012 that she had learned a lesson, Richardson then worked as an agent for five home care agencies enrolled in the Medicaid program, disguising her identify by using names of family members, Ellison said. The agencies received more than $7.7 million from the state, often billing for services that were not provided and in some instances, using the identities of people who did not even live in Minnesota.

Hundreds of thousands of dollars of claims were the result of illegal kickback or check-splitting agreements between clients and employees, many of whom were friends and family members of Richardson and Burrell, he said.

Staff writers Pamela Miller and Brandon Stahl contributed to this report.

Two more convicted in largest case of Medicaid fraud in Minnesota state court history

Two more convicted in largest case of Medicaid fraud in Minnesota state court history

Two people were convicted this past week for defrauding Minnesota's Medicaid program of $7.7 million.

Lillian Richardson and Bridgett Burrell were found guilty of all charges that the Minnesota Attorney General's office brought against them — one count each of racketeering and eight counts a piece of aiding and abetting theft by swindle. The convictions were part of the largest case of Medicaid fraud in state court history.

"It's shameful that these defendants illegally set up home care..

Richardson, who was first convicted of Medicaid fraud in 2012, defrauded the state Medicaid program through five home care agenciesThose agencies were enrolled in the Medicaid program under the names of her family members. Her sister, Burrell, was a part of this operation.

Arizona Nursing Center Where Woman in Vegetative State Was Raped Will Close

SourceURL: https://www.nytimes.com/2019/02/07/us/hacienda-healthcare-phoenix-closing.html

Arizona Nursing Center Where Woman in Vegetative State Was Raped Will CloseArizona Nursing Center Where Woman in Vegetative State Was Raped Will Close

Hacienda HealthCare in Phoenix. It is closing its facility for patients in long-term disability care.CreditRoss D. Franklin/Associated Press

Image

Hacienda HealthCare in Phoenix. It is closing its facility for patients in long-term disability care.CreditCreditRoss D. Franklin/Associated Press

By Matt Stevens

Feb. 7, 2019

The care facility in Arizona where an incapacitated woman was raped and later gave birth will soon be closed, the nursing home's operator announced on Thursday.

In a statement, the operator, Hacienda HealthCare, said it was working to determine exactly how it would move its patients from the Phoenix facility elsewhere and did not specify a location. It pledged to do "everything in our power" to ensure that the transition would be smooth.

A spokesman for the company said 37 patients would be affected.

"The Hacienda Healthcare board of directors, after a great deal of careful consideration, has come to understand that it is simply not sustainable to continue to operate our Intermediate Care Facility for the Intellectually Disabled," the company's statement said, adding that the board had voted on Feb. 1 to close the nursing center.

State agencies were notified of the board vote the same day.

Some state officials, though, reacted Thursday with surprise. They said that when they met with Hacienda officials on Monday, the company acknowledged the board's vote, but did not provide notice to terminate its contract or provide a transition plan as required by its contract with the state. As recently as Thursday, state officials added, discussions about how to maintain patient care at the center were continuing.

"We find this announcement very concerning," said Patrick Ptak, a spokesman for Gov. Douglas A. Ducey. "State agencies have been actively working to increase oversight at this facility to ensure patients are safe and well cared for. For some patients at the facility, this is the only home they know or remember. Forcing this medically fragile community to move should be a last resort. Everyone's first priority should be protecting their health and safety."

The announcement came about two weeks after a former nurse there, Nathan D. Sutherland, was charged with having sexually assaulted the woman. Mr. Sutherland, 36, pleaded not guilty on Tuesday to that charge and to a count of child abuse.

Over the past several weeks, the case has rattled Arizona, raising concerns about the way patients in long-term disability care are treated and placing Hacienda HealthCare under intense scrutiny.

The criminal case started to unfold in late December, when a woman at Hacienda who cannot talk or walk unexpectedly gave birth to a boy. (The baby is said to be doing well and is in the custody of the woman's family.)

Over the weeks that followed, the investigation became the main focus of the Phoenix Police Department, its chief said, and led to questions about the company's operations and conduct. A DNA sample taken from Mr. Sutherland, who was assigned to treat the woman, was eventually found to match that of the newborn, the police said.

Earlier this week, Governor Ducey raised the possibility of deploying the state attorney general's office in a wide-ranging investigation into the company. The governor requested an inquiry into how Hacienda employees did not know that the 29-year-old patient, who has been at the nursing center since 1992, had been raped or notice that she was pregnant, according to a copy of the letter he sent the attorney general, Mark Brnovich.

It was not clear Thursday what action Mr. Brnovich's office planned to take in response to the governor's letter. A spokeswoman for the attorney general declined to comment.

In addition to investigating the woman's case, the governor requested a broader investigation into Hacienda's management, with a focus on possible financial fraud and "violations of Arizona's civil rights act" in its company culture. Since 2016, the Arizona health agency that manages the state's Medicaid program has been investigating $3.4 million in possible Medicaid fraud at Hacienda.

Since the assault case was made public, Hacienda officials have pledged to cooperate with local and state investigators, as well as work to regain the public's trust. The company recently hired a former top prosecutor in Maricopa County, where Phoenix is located, to conduct its own investigation into the assault.
Elisha Brown and Matthew Haag contributed reporting.

A version of this article appears in print on Feb. 7, 2019, on Page A13 of the New York edition with the headline: Nursing Center in Rape Case Will Close. Order Reprints | Today's Paper | Subscribe

Southern WV doctor agrees to repay money after fraud plea

SourceURL: https://www.wvgazettemail.com/news/cops_and_courts/southern-wv-doctor-agrees-to-repay-money-after-fraud-plea/article_1c704dfb-3e78-5564-8ce6-0b8c592c23d8.html

Southern WV doctor agrees to repay money after fraud plea

clipart.com

A Southern West Virginia doctor has agreed to repay more than $200,000 after he pleaded guilty last week to health-care fraud.

Dr. Manuel C. Barit, 71, admitted last week that he defrauded Medicare and Medicaid, according to a news release from U.S. Attorney Mike Stuart's office. Barit, of Raleigh County, was the only practicing physician at the Mullens Family Clinic, and submitted claims to Medicare and Medicaid for treating patients at the clinic on dates when Barit was out of the country.

The scheme began in October 2013 and lasted into this year, according to Stuart's office.

Barit was indicted in May 2018 on the health-care fraud charge, as well as 19 counts of distribution of controlled substances outside the bounds of a legitimate medical practice. Those charges were dropped as a result of the plea agreement, according to court records.

On Monday, Stuart's office announced Barit's agreement to repay the money. The amount, according to Stuart, includes full restitution to the West Virginia Medicaid program.

Barit faces up to 10 years in prison and a fine of up to $250,000 when he is sentenced by U.S. District Judge Irene Berger on May 16.

Former Tennessee nurse charged with patient abuse, reckless homicide after woman's death

SourceURL: https://www.fox13memphis.com/top-stories/former-tennessee-nurse-charged-with-patient-abuse-reckless-homicide-after-woman-s-death/915197156

Former Tennessee nurse charged with patient abuse, reckless homicide after woman's death

Updated: Feb 5, 2019 - 4:32 PM
Loading...

-

NASHVILLE, Tenn. (WZTV) — A Tennessee nurse is behind bars on charges of patient abuse and reckless homicide following an investigation by the Medicaid Fraud Control Unit and the Tennessee Bureau of Investigation.

TBI agents in Nov. 2018, along with the Vulnerable Adult Protective Investigate Team with the Davidson County District Attorney General's Office, started

investigating the circumstances surrounding the death of Charlene Murphey.

Murphey was a patient at Vanderbilt University Medical Center on Dec. 26, 2017 while authorities said Radonda Vaught was a registered nurse, part of the team providing Murphey's treatment.

Inspection reports from the Centers for Medicare and Medicaid Services obtained by WZTV show that the nurse's deadly error happened just days after the patient was admitted for headaches, swelling of the brain and other symptoms.

A doctor ordered two milligrams of Versed, a drug used to treat anxiety at 2:47 p.m. on Dec. 26, but inspection reports say the nurse instead administered 10 milligrams of Vecuronium, a neuromuscular blocking agent which causes paralysis sometimes used during surgeries.

A review of the automatic dispensing cabinet showed the nurse used the override feature to gain access to the paralyzing agent.

A physician called for code in the PET scanner at 3:45 p.m. and noted that the patient identified by TBI as Murphey was "pulseless and unresponsive on arrival." Murphey was readmitted to neuro critical care after suffering cardiac arrest while undergoing the PET scan and died on Dec. 27.

The TBI said agents learned that actions taken by Vaught were responsible for Murphey's death.

Vaught is no longer an employee with Vanderbilt University Medical Center.

A representative with Vanderbilt University Medical Center issued the following statement about the charges against the former nurse.

> *"We learned today that a nurse formerly employed by VUMC has been arrested and criminally charged in connection with an incident that occurred in December 2017 in which a patient received medication not ordered for her and ultimately died. We have cooperated fully with regulatory and law enforcement agencies investigating the incident. That includes providing background information about the event itself, along with physical evidence, requested health records information and other documents." - John Howser, Chief Communications Officer for VUMC*

The Davidson County Grand Jury returned indictments charging Vaught with one count of impaired adult abuse and one count of reckless homicide.

Vaught was arrested and booked into the Davidson County Jail on a $50,000 bond Monday.

Xerox/Conduent Settling Its $2 Billion Dental Medicaid Fraud Case with Texas? - Texas Dentists for Medicaid Reform

SourceURL: https://www.tdmr.org/xerox-conduent-settling-its-2-billion-medicaid-fraud-case-with-texas/

Xerox/Conduent Settling Its $2 Billion Dental Medicaid Fraud Case with Texas?

February 7, 2019 By TDMR Leave a Comment

TDMR has learned that Xerox/Conduent is in talks with the Office of Attorney General to settle the $2 billion Medicaid fraud case against the company, once Texas' Medicaid claims administrator. The amount is calculated to include triple

damages and civil penalties for every illegal act performed for almost two hundred thousand alleged illegal acts.

Started back in 2014

Xerox/Conduent was fired as the lead contractor from the Texas Medicaid and Health Partnership and the legal action brought against it back in May of 2014. The state alleged that it had cost taxpayers hundreds of millions of dollars by rubber-stamping orthodontic prior authorizations that did not meet the state's standards for medical necessity.

The legal action came three months after several dentists filed a similar lawsuit against the company. Neither the state or Xerox/Conduent has shown any interest in settling this outstanding case.

Xerox/Conduent misrepresented PA process

However, the state lawsuit further alleges that the company continuously lied to state officials from 2004 to 2012 falsely reassuring them that the company's Medicaid orthodontic prior approval (PA) process was sound. But, as has already been reported long-time since, the company was doing no review at all, using untrained dental "specialists" to simply add up HLD scores.

Xerox/Conduent's legal defense has been that state officials were well aware of the company's deficient PA process. TDMR has published stories with court documents as available backing the claim. It is true that state officials like then-State Dental Director Linda Altenhoff knew the truth as early as 2008 and nothing was done to get the company to change its ways.

Court documents show extent of case against company

However, court documents now obtained by TDMR show the extent of the state's case against the company and the testimony and documentary evidence it will rely on to prove its case should it ever go to court.

This is the first time we have seen specifics relating to the claims of misrepresentation.

The evidence is compelling.

We already knew that Xerox didn't follow the state-approved policies and procedures that required a review of ALL orthodontic prior authorization requests by the Xerox/Conduent dental director. In actual fact, 90% of the requests were never sent to the dental director.

Yet the company told state officials at various times over the years that it was.

Three examples from one court document:

1. "Xerox's 2002 Proposal represented that one of the criteria reviewed in performing quality assurance of prior authorization is whether "the PA request [was] adjudicated correctly, based on the HHSC-approved procedures and medical criteria.""

2. "In response to a SAR (State Action Request) requesting TMHP"s current quality assurance process being performed for prior authorization, on July 20, 2009, Xerox submitted a quality assurance policy and procedure ("P&P") that stated one of the criteria for quality assurance is whether "[a]ll medical facts are considered and documented in the PA determination."

3. Xerox/Conduent's corporate representative Erik Holt testified in a deposition that the policies and procedures that were given to the state "just aren't accurate. That is not the way the flow and the … work happened at TMHP."

Xerox/Conduent SEC filing shows settlement talks

So, with the specter of a jury trial within the next year or so, it is not surprising that the company would want to settle. It indicated its desire to do so in its most recent SEC filing which in part says:

"During October of 2018, discussions with the State were undertaken to determine if a mutually acceptable settlement might be reached. Those discussions were not productive.

"In the wake of those discussions, we have recorded an additional $72 million reserve during the third quarter of 2018, increasing our aggregate reserve for this matter as of September 30, 2018, to $110 million.

"We are not able to determine or predict with any degree of certainty the ultimate outcome of any future settlement discussions or this proceeding or to

estimate any reasonably possible loss or range of losses, if any, in excess of the $110 million the Company has accrued."

Settlement needs to be huge

The question arises how much would a settlement be?

Xerox/Conduent successfully avoided any major scrutiny from 2011 to 2014. Those who remember know that the HHSC-OIG under Jack Stick and Doug Wilson focussed exclusively on blaming Medicaid dental providers. Former IG Doug Wilson told a provider in an informal meeting just before the lawsuit against Xerox/Conduent was made public that the orthodontic debacle had "nothing to do with Xerox."

It appears that media pressure in early 2014 had a lot to do with the filing of the suit. Just a few weeks before the filing became public, the Texas Tribune published a major story which was republished in the New York Times about how the company had evaded scrutiny and questioned why the state was still doing business with it. The Statesman published a similar story shortly after the announcement of the lawsuit.

Last year the State of Texas had to repay the Federal Government over $133 million that the feds demanded after an HHS-OIG audit determined that Xerox/Conduent had not followed state Medicaid guidelines when reviewing the orthodontic PA requests. The Texas share was another $58 million.

Considering the additional millions of dollars in attorney fees and court time that have been incurred by the OAG over the last five years, any settlement under $200 million would be a further waste of taxpayer monies considering the state was seeking $2 billion.

We'll have to see what happens.

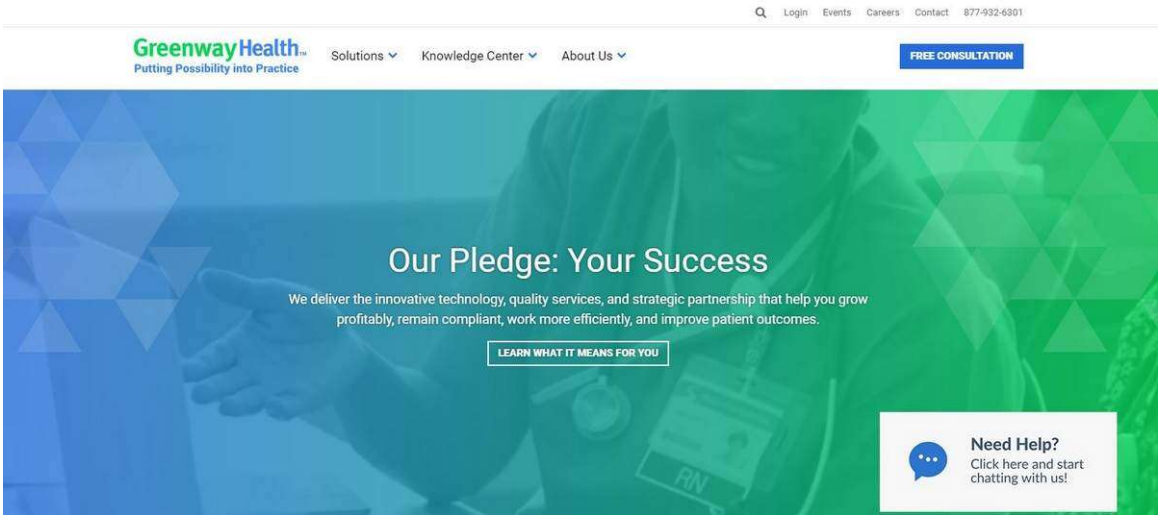
Tampa's Greenway Health to pay $57.25M in fraud settlement

SourceURL: https://www.tampabay.com/business/tampas-greenway-health-to-pay-5725m-in-fraud-settlement-20190211/

Tampa's Greenway Health to pay $57.25M in fraud settlement

In a settlement reached Feb. 6, authorities said that Greenway lied to both customers and the federal government by telling them its software met standards that would qualify customers for payments.

1



Tampa's Greenway Health will pay $57.25 million in a settlement with the Department of Justice over Medicare and Medicaid fraud. Pictured is its website in February. [Courtesy of Greenway Health]

By Malena Carollo

Published 17 minutes ago

Tampa medical records management company Greenway Health has agreed to pay $57.25 million in a settlement with the U.S. Department of Justice over alleged Medicare fraud.

In a settlement reached last week, authorities said that Greenway lied to both customers and the federal government by telling them its records management software met standards that would qualify customers for payments through a Medicare and Medicaid incentive program.

"Electronic health records are critically important to the health care decision process," said Jody Hunt, assistant attorney general of the Department of Justice's Civil Division. "This resolution demonstrates our continued commitment to pursue (electronic health record) vendors who misrepresent the capabilities of their products."

Greenway provides software to health care providers around the country, including in Vermont, where the lawsuit was filed. According to the filing, Greenway allegedly passed the Department of Health and Human Services certification by modifying the software that it presented for auditing to look as if it met the qualifications.

"Had Greenway disclosed that its 'Prime Suite' software did not meet" certification criteria, the lawsuit said, "it would not have been certified and its users would not have been eligible for incentive payments."

Its customers, the Department of Justice said in a release, collected payments through the incentive program falsely believing they were eligible. It said Greenway attracted new customers by touting the incentives they could receive with their software.

The settlement is not an admission of guilt, Greenway said in a statement.

"This agreement allows us to focus on innovation while collaborating with our customers to improve the delivery of healthcare and the health of our communities,"said CEO Richard Atkin.

Contact Malena Carollo at mcarollo@tampabay.com or (727) 892-2249. Follow @malenacarollo.

Las Vegas woman's sentence suspended in Medicaid fraud case

SourceURL: https://news3lv.com/news/local/las-vegas-woman-sentenced-in-medicaid-fraud-case

Las Vegas woman's sentence suspended in Medicaid fraud case

by News 3 Staff

Monday, February 11th 2019

Doretha Scott has been sentenced to up to three years in prison on charges of Medicaid fraud, according to the Nevada Attorney General's Office. (Photo courtesy LVMPD)

LAS VEGAS (KSNV) — A 65-year-old Las Vegas woman had her prison sentence suspended Monday after facing charges stemming from Medicaid fraud, according to prosecutors.

Nevada Attorney General Aaron Ford's office says Doretha Scott was charged with submitting false claims to Nevada Medicaid for more than a year, from December 2015 to January 2017.

The Medicaid Fraud Control Unit got a tip that Scott was using her business, Men on the Rise, to submit claims for services that were never given to Medicaid recipients, according to a statement from Ford's office.

Prosecutors said Scott knowingly submitted false claims, some of which purported that Scott provided the services, and an investigation determined her documentation for the claims was false.

Scott faced a year to three years in prison. She has also been ordered to pay more than $160,000 in restitution.

Minnesota Women Convicted in Major Medicaid Fraud Case

Minnesota Women Convicted in Major Medicaid Fraud Case

February 9, 2019

Getty Images/iStockphoto
St. Paul, MN (KROC-AM News) - Two Minnesota women charged with being part of what has been described as the largest Medicaid fraud case in state history have been found guilty of racketeering and theft by swindle charges.

A news release issued by the Minnesota Attorney General's Office says Lillian Richardson and Bridgett Burrell were the last of the seven people charged in the case to be convicted. The other five previously pleaded guilty.

> *"Hundreds of thousands of dollars of claims were the result of illegal kickback or check-splitting agreements between clients and employees, many of whom were friends and family members of Richardson and Burrell," the release said.*

Richardson was accused of being the ringleader of a scam that, according to prosecutors, resulted in the theft of over $7.5-million from the government health care program.

Minnesota court records show she was convicted of a Medicaid Fraud Charge in 2012 and was sentenced to 10-years on probation, but that was amended in 2017 and was ordered to serve a 21-month prison sentence. Richardson's original sentence included $65,000 in restitution and she still owes over $64,000.

Mississippi woman faces tax evasion, Medicaid fraud charges

SourceURL: https://www.kark.com/news/local-news/ms-woman-faces-tax-evasion-medicaid-fraud-charges-in-ar/1760020760

MS woman faces tax evasion, Medicaid fraud charges in AR

Posted: Feb 06, 2019 03:11 PM CST

Updated: Feb 06, 2019 03:11 PM CST

LITTLE ROCK, Ark. (News Release) – The owner of Bridge of Faith Hospice & Palliative Care in Helena-West Helena has been arrested on charges

separate, but in addition to the previous charges of engaging in a criminal enterprise and Medicaid fraud she is currently facing.

According to a press release from Attorney General Leslie Rutledge, Charline Brandon, 62, of Cleveland, Mississippi, is charged with attempting to evade or defeat taxes, a Class C felony, from 2010 to March 2017. Brandon was arrested for fraudulently billing the Medicaid program in Arkansas in October 2017. It was subsequently learned that from September 2013 through December 2016, Bridge of Faith Hospice & Palliative Care was paid gross income of $1,567,432.82 by Medicaid and Medicare and never filed an income tax return in Arkansas. Brandon turned herself in to the Pulaski County District Court. She currently faces similar charges in Mississippi.

“Brandon’s laundry list of charges include finding ways to steal from the Arkansas Medicaid Program and avoid paying taxes,” said Attorney General Rutledge. “Brandon’s failure to pay taxes on behalf of the company or from her personal income to the State of Arkansas hurt law-abiding Arkansas families and businesses who work hard to follow the laws and serve Arkansans.”

This case was referred to the Arkansas Attorney General’s office by the Mississippi Medicaid Fraud Control Unit and the U.S. Department of Health & Human Services Office of Inspector General.

Medicaid fraud occurs when providers use the Medicaid program to obtain money to which they are not entitled. To report Medicaid fraud or abuse or neglect in residential care facilities, contact the Attorney General’s Medicaid fraud hotline at (866) 810-0016 or oag@arkansasag.gov.