consulting | training | free webinars

clay@mostlymedicaid.com | 919-727-9231

Medicaid Fraud Curator

January 4th , 2019

Total this week: $20M+

1. Dillwyn Couple Sentenced on Federal Healthcare Fraud Charges
2. Hilliard couple convicted of health care fraud
3. Nevada state government cracks down on improper Medicaid billing
4. Minnesota Attorney General Charges Bloomington Man With Defrauding State Of $260K
5. AG Ferguson: $2.7M awarded in first-ever Washington civil Medicaid false claims trial | Washington State
6. Woman Pleads Guilty In Tewksbury Medicaid Fraud Case
7. Lawsuit says Christiana Care defrauded taxpayers with 'kickback scheme'
8. 2 healthcare execs plead guilty to Medicaid fraud
9. Minnesota AG charges man alleged to have defrauded state of ...
10. Woman Faces $2.5M Restitution After Admitting Role In Fraud Scheme
11. Unlicensed dentist from N.J. convicted in $2M Medicaid fraud scheme
12. Dearborn entrepreneur charged in $1M health care fraud
13. Orlando Home Care Company Owner Faces Charges of Medicaid Fraud
14. Medicare, Medicaid Exclude 200% More Docs for Healthcare Fraud
15. Pharmacist charged in $1.2 million health care fraud case
16. Former NCSU booster gets 18 months in prison for Medicaid fraud :: WRAL.com
17. Former psychologist, wife sentenced to prison for Medicaid fraud
18. Maryland health care aide charged with Medicaid fraud of almost $450K
19. Waterbury woman charged with Medicaid fraud
20. Alaska woman sentenced to probation for Medicaid fraud
21. 11 healthcare fraud, lawsuit stories of 2018: ASCs, surgeons & more

22. Aurora Health Care Pays $12M to Settle Healthcare Fraud Claims
23. Nashville CEO forged signatures for fake therapy, U.S. Attorney says
24. Operator of medical equipment company sentenced on fraud charges

SourceURL: http://www.nbc29.com/story/39599565/dillwyn-couple-sentenced-on-federal-health-care-fraud-charges

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.

Hilliard couple convicted of health care fraud

by CHRIS WHITE

Wednesday, December 19th 2018

FILE- Health care fraud. (MGN ONLINE)

A Hilliard couple was convicted of health care fraud after illegally marketing prescriptions to low-income neighborhoods from their Dublin pharmacy.

U.S. Attorney Benjamin C. Glassman said Darrell L. Bryant, 44, and Gifty Kusi, 35, owned and managed Health and Wellness Pharmacy on Blazer Parkway in Dublin and Health and Wellness Medical Center, a suboxone clinic, also located in Dublin.

The couple marketed prescription creams to low-income neighborhoods and mail those creams to Medicaid customers. Glassman said they also billed counseling services that weren't provided, and billed for individual counseling sessions that happened in a group setting.

Medicaid was billed $3 million for the creams. Glassman said Bryant and Kusi marketed the creams through the suboxone clinic, Sav-a-Lot and through a mobile van unit. Customers at Sav-a-Lot and in low-income neighborhoods were asked to fill out a survey asking about any conditions that they suffered from. Glassman said they would then receive the compound creams in the mail every month, even when customers asked for them stop.

One of the couple's co-conspirator, Dr. Jornell Rivera, who also owned the Health and Wellness Medical Center, pleaded guilty this past May to making false statements related to health care matters. His sentence will begin January 11.

Another co-conspirator, Dr. Bernard Oppong, was charged in a seven-count indictment this past October.

ABC 6/FOX 28 will continue to follow this story.

Nevada state government cracks down on improper Medicaid billing

William Howard | Shutterstock.com

A six-month moratorium on Medicaid enrollment for some mental health providers is in place in response to concerns the providers were performing services without proper qualifications.

The Nevada Department of Health and Human Services (NDHHS), Division of Health Care Financing and Policy (DHCFP), which oversees Medicaid administration, recently held a public workshop in Carson City with stake-holders in Elko and Las Vegas via video-conference, to discuss "an enrollment moratorium on Qualified Mental Health Associates (QMHA) and Qualified Behavioral Aides (QBA)."

The meeting was called after several mental health groups raised concerns about some providers who were enrolled in the program performing services without proper qualifications, the agency said.

During the six-month moratorium, the DHCFP will collaborate with the DPBH "to develop certifications and oversights to rehabilitative mental health services and the providers that render such services," the agency said. It announced that their review will impact all "provider types that utilize QMHAs and QBAs in their business models."

The agency's acting administrator, Cody Phinney, expressed concerns about potential improper billing for codes for medication training and support and crisis intervention, which are frequently used by QBAs and QMHAs. Her concerns about overbilling for mental health services come after the agency she heads has already investigated more than $73 million in fraudulently paid behavioral health claims through Medicaid this year alone.

According to state data, 85 mental health providers were flagged for investigation last fiscal year and the state terminated contracts with 33 providers. These 33 cases were referred to the state attorney general's Medicaid Fraud Control Unit, the agency reported. It has only recovered about $10 million, or 13 percent, from such claims.

Through Medicaid expansion, Nevada saw an enrollment increase of 90 percent from Fall 2013 to March 2017, according to state records. Nevada had the

second-highest increase in Medicaid enrollment in the U.S., behind Kentucky, during this time-period.

Phinney has said that Medicaid expansion "has certainly exacerbated the problem of fraudulent or improper claims in the field of behavioral health."

The agency attempted to strengthen prior authorization rules for psychotherapy and neurotherapy earlier this year but ended up reversing its decision after receiving backlash from providers and patients.

"What we've discovered in the last year or so in talking with the community and reviewing data is that we clearly need to increase the quality and oversight," Phinney said. "The moratorium is about fixing those policies to make sure … we're teaching people at the front end about evidence-based processes and requiring all those skills at the front end so we don't get to the issue."

Under Nevada law, qualified mental health associates are required to hold a bachelor's degree. Qualified behavioral aides are legally allowed to practice having only received a high school diploma.

Neither qualified mental health associates nor behavioral aides are required to be licensed in the state of Nevada.

The current process for these providers to become enrolled through Medicaid first involves a background check prior to agency approval. Once authorized, they are supposed to work under a clinician's supervision. The state does not check on their performance during the five years they are authorized, only when they re-apply to re-enroll for another authorization period.

Lack of oversight has created opportunities for providers to administer poor or inappropriate care to the state's most vulnerable patients, the agency admitted, resulting in the need for a moratorium.

During the moratorium, the state will host public workshops and assemble focus groups to create new regulations over the next six months. During that time, providers who have current registrations with the state will be allowed to re-enroll in the program. QBAs and QMHAs will be able to keep their positions during this time. However, after the six-month period, Phinney said the agency will decide how to work with these providers so that they can also comply with the new requirements.

According to **Paritytrack.org**, Nevada was among 32 states that received an F grade for its mental health coverage laws. Nevada scored a 54 out of 100 and ranked in the top ten of 32 failing states at 28 out of 50.

The organization recently released a report card of each state evaluating how well each did 10 years after the passage of the Mental Health Parity and Addiction Equity Act. The federal law mandated that healthcare coverage of illnesses of the brain, like depression or drug addiction, be provided at the same level of care as diseases like diabetes or cancer.

The state's efforts come after Attorney General Adam Laxalt's office announced the successful prosecution of several Medicaid fraud cases earlier this year. While victories, the **The Las Vegas Review Journal** suggests they are only a fraction of the problem. Medicaid fraud, the Review Journal argues, is "undoubtedly adding to the $56 million deficit Nevada Medicaid predicts it will face in the 2019 fiscal year, up from last year's $30 million forecast at this time."

SourceURL: https://www.voiceofalexandria.com/news/state/minnesota-attorney-general-charges-bloomington-man-with-defrauding-state-of/article_7b552a3e-0fa9-11e9-8d99-47405e940957.html

Minnesota Attorney General Charges Bloomington Man With Defrauding State Of $260K

(St. Paul, MN) -- The Minnesota Attorney General's Office brought charges Wednesday against a man alleged to have defrauded the state medical assistance program out of more than 260-thousand dollars. State Attorney

General Lori Swanson said Abdi Ali Gure of Bloomington submitted false claims for care he hadn't received or from a provider not approved by the state. Gure faces seven counts of theft by false representation for billing the Department of Human Services for personal care assistance services that weren't delivered between 2013 and 2015. According to the complaint, Gure is the owner of Diversified Home Care, a provider that is "enrolled in the Medicaid program as a Personal Care Provider Organization." Investigators with the office's Medicaid Fraud Control Unit, said Gure submitted false claims to the state and ran various schemes through the organization.

AG Ferguson: $2.7M awarded in first-ever Washington civil Medicaid false claims trial

FOR IMMEDIATE RELEASE:

Dec 13 2018

Marysville company defrauded taxpayers for years

SEATTLE — Attorney General Bob Ferguson today announced a judgment of more than $2.79 million in his lawsuit against a Marysville company that defrauded taxpayers nearly $1 million over a period of years. This is the first trial in a Medicaid False Claims Act case in Washington state history. Ferguson's agency-request legislation renewed the act in 2016.

"Medicaid dollars are a precious resource meant to care for the most vulnerable among us," Ferguson said. "This result will help future efforts to fight fraud and ensure Medicaid funds go toward Washingtonians' health care needs."

King County Superior Court Judge John Ruhl ruled that the company, Relationship Toward Self-Discovery (RTS), its owner and president Laird Richmond, and manager and treasurer Jason Lowery were all liable for fraud and the presentation of false Medicaid claims for payment under the Washington Medicaid False Claims Act.

RTS operated a residential care facility in Marysville for developmentally disabled adults. The facility closed in 2016.

While it was in operation, RTS required employees to stay overnight at the facility in order to provide care to the residents as needed. Washington law requires employers to pay this type of employee a "sleep rate," and their regular rate if they are actually called upon to perform their job.

In its Medicaid claims from 2012 through 2015, RTS reported paying 60,328 sleep hours to its employees, and received $928,221 in reimbursement from Medicaid.

In fact, RTS did not pay its employees this rate at all.

RTS paid these employees a small amount of overtime instead. In 2012 alone, the difference between the actual amount paid to employees and the amount reported to Medicaid totaled more than $200,000.

The conduct came to light because of a whistleblower. A former bookkeeper reported the company's conduct in a complaint to the court.

Ferguson filed his lawsuit April 16, 2016. Since then, the company folded and Richmond died. The company and Richmond's estate are still subject to the court's judgment.

Judge Ruhl found that RTS, Richmond and Lowery defrauded Medicaid of $928,221. Because the case went to trial, the law requires the actual damages be tripled, resulting in $2,784,663 in damages. The court also assessed a $5,500 civil penalty, and ordered the defendants to pay the state's costs and fees related to bringing the case. The amount of those fees will be determined at a later date.

The whistleblower is entitled to 25 percent of the state's recovery. The remaining 75 percent of the funds go toward future Medicaid fraud enforcement efforts.

Assistant Attorneys General Katrina King, Matthew Kuehn and Senior Investigators Kim Triplett, Ses Maiava, Chief Forensic Analyst Sonja Winkelman and paralegal Saphron Weatherly handled the case for Washington.

The Attorney General's use of the Medicaid False Claims Act has been highly effective. In a 2015 report, a legislative committee noted that since the act's original passage up to that time, civil fraud recoveries increased 28 percent, and the state has recovered $3 for every $1 invested in enforcement under the act.

Report Medicaid fraud in Washington

The Attorney General's Medicaid Fraud Control Division is responsible for the investigation and prosecution of Medicaid provider fraud. The division also has oversight of all residential facility abuse and neglect matters, bringing criminal and civil prosecutions regarding abuse and neglect in cases involving vulnerable adults residing in residential facilities.

Report suspected Medicaid fraud at 360-586-8888 or MFCUreferrals@atg.wa.gov.

You can also report provider fraud via the AGO website ww.atg.wa.gov/medicaid-fraud.

-30-

The Office of the Attorney General is the chief legal office for the state of Washington with attorneys and staff in 27 divisions across the state providing legal services to roughly 200 state agencies, boards and commissions. Visit www.atg.wa.gov to learn more.

Contacts:

Brionna Aho, Communications Director, (360) 753-2727;
brionna.aho@atg.wa.gov

Woman Pleads Guilty In Tewksbury Medicaid Fraud Case

Dawna DeMarco, 33, of Tewksbury, was sentenced to one year in prison and ordered to repay $12,360.

By Dave Copeland, Patch Staff | Dec 14, 2018 10:34 am ET | Updated Dec 14, 2018 10:37 am ET

TEWKSBURY, MA -- A Tewksbury woman who continued to submit timesheets for Medicaid reimbursement after the woman she was caring for died pleaded guilty Thursday to one count of Medicaid false claims and one count of larceny over $250. Judge Maureen Hogan ordered Dawna DeMarco, 33, to repay $12,360 and sentenced her to one year in a house of correction.

"This defendant took advantage of our MassHealth system and stole health care resources from Massachusetts taxpayers and patients," Attorney General Maura

Healey said in a press release. "We will investigate those who commit this fraud and take action to ensure that it does not continue."

DeMarco was indicted in September. DeMarco was hired as a personal care aide for her aunt, who died in October 2016. According to the indictment, she submitted time sheets for hours she did not work beginning in September 2016 and continuing through April of last year, more than five months after her aunt had died.

Christiana Care to respond to claims of illegal Medicaid kickbacks next week

Karl Baker, Delaware News Journal Published 10:20 a.m. ET Dec. 28, 2018 | Updated 10:39 a.m. ET Dec. 28, 2018

A lawsuit claims Christiana Care defrauded taxpayers through a "kickback scheme" funneling Medicaid payments to independent doctors in exchange for patient referrals. 9/20/18 Damian Giletto/The News Journal

Buy Photo

Neonatal unit at Christiana Hospital.(Photo: Jennifer Corbett, The News Journal)Buy Photo

Christiana Care, Delaware's largest hospital system, has until Jan. 4 to respond to claims that it defrauded taxpayers by funneling Medicaid payments to independent doctors in exchange for lucrative patient referrals.

The hospital's former Chief Compliance Officer Ronald Sherman brought the charges of a "kickback scheme" last year in a False Claims Act lawsuit filed in the U.S. District Court for Delaware.

Unsealed last summer, the suit claims that between 2010 and 2014, Christiana Care allowed medical specialists from a private practice called Neonatology Associates to bill the federal government for care of critically ill newborns that actually had been provided by the hospital's own staff within its neonatal intensive care unit.

Christiana Care's flagship campus in Stanton houses the only high-risk delivering hospital in Delaware. Its maternity wing, the 32nd largest in the country, also is an engine for profits, according to experts — one that hasn't been squeezed by hyper-competition in the post-Obamacare health care environment.

Sherman's suit further claims that Neonatology Associates, in exchange for their allegedly unearned billings, would refer patients to Christiana Care rather than to its competitors in the region.

The deeds allegedly occurred after Christiana Care settled for $3.3 million separate, yet similar, charges of Medicare and Medicaid fraud first brought in 2005 by two neurology physicians.

Buy Photo
Neonatal unit at Christiana Hospital. (Photo: Jennifer Corbett, The News Journal)

In 2010, then-Delaware Attorney General Beau Biden cheered the settlement, saying it sent a clear message to anyone "who attempts to defraud taxpayers."

It also bound Christiana Care to new reporting rules outlined in a Corporate Integrity Agreement, a form of probation for certain hospitals that receive Medicaid and Medicare payments.

Archives: Christiana Care pays $3.3 million to end whistleblower lawsuit in 2010

Background: Christiana plans new 8-story women and children's building

Yet, just months after the settlement, a hospital auditor named Rhonda Mullins confronted Sherman with new allegations about kickbacks to Neonatology Associates, according to the lawsuit.

As chief compliance officer, it was Sherman's job to ensure that Christiana Care's operations complied with all laws as it provided more than $1.5 billion worth of care each year.

After learning about the possible fraud from Mullins, Sherman launched an investigation, according to his lawsuit.

Four years later, Sherman was fired, just after Dr. Janice Nevin became CEO of the hospital, according to the lawsuit.

Security escorted him out, he claims, so that he "would have in his possession as little written documentation as possible to support his allegations."

Janice Nevin (Photo: Submitted image)

In response to questions about the case last fall, Christiana Care spokesman Shane Hoffman said the hospital learned of the allegations in 2010 and at that time investigated them thoroughly.

"We implemented safeguards and took appropriate actions to ensure continued compliance with the law. These included confirming processes and protocols for the appropriate use of physician assistants and nurse practitioners in delivering high-quality, safe care."

Hoffman noted that federal prosecutors declined to join Sherman on the plaintiff's side in the lawsuit.

In any whistleblower case, which alleges misuse of federal dollars under the False Claims Act, U.S. prosecutors must examine the claims and decide whether to bring government resources into the litigation.

It is a move that can buttress charges with a greater appearance of legitimacy.

Sherman's attorney said the government's decision not to intervene does not mean Sherman's fraud charges are unsubstantiated.

"The government declines to intervene in the vast majority of cases, including many that have merit," said the attorney, Dan Miller, last summer.

He pointed to a recent $120 million False Claims Act settlement that his firm, Berger and Montague, reached with a national nursing home company after federal prosecutors initially declined to join that case.

Officials from the U.S. Attorney's office in Wilmington would not comment for this story.

In early October, Christiana Care, which is Delaware's largest private employer, retained outside attorneys for its defense in this case.

Because those attorneys had not yet studied the facts, a judge granted their request to postpone until early January Christiana Care's date to respond to the charges.

Lead attorney Paul Logan did not reply to a request to comment for this story.

Contact Karl Baker at kbaker@delawareonline.com or (302) 324-2329. Follow him on Twitter @kbaker6.

2 healthcare execs plead guilty to Medicaid fraud

Written by Morgan Haefner | December 11, 2018 | Print | Email

Two healthcare executives pleaded guilty to charges of conspiracy to commit healthcare fraud Dec. 7, according to the Department of Justice.

Lisa Carol Raymond and Robert Paul Maglicic were charged with participating in a scheme to defraud the South Carolina Medicaid program through Southern Support Services, a provider in Florence, S.C. Southern Support Services' owner, Shepard Lee Spruill, was previously prosecuted for defrauding North Carolina's Medicaid program and sentenced to eight years in federal prison in July 2018.

According to the Department of Justice, Mr. Maglicic and Ms. Raymond fabricated records to support billings from Southern Support Services. The provider fraudulently billed the South Carolina Medicaid program between October 2013 and November 2014 for more than $595,000 in fictitious behavioral health services, according to the allegations. The Medicaid program also paid Southern Support Services another $1.4 million for behavioral health services it did not render between December 2014 and April 2015, according to the accusations. In total, the department projects Medicaid paid more than $2 million due to improper billing on behalf of the defendants.

Mr. Maglicic and Ms. Raymond face up to 10 years in prison for their alleged participation in the scheme, as well as fines, supervised release and mandatory restitution, according toson more than $750,000 between 2011 and 2016

Woman Faces $2.5M Restitution After Admitting Role In Fraud Scheme

District Court in Bridgeport. Photo Credit: *Google Maps*

A Fairfield County woman has admitted to her role in an elaborate scheme to defraud Medicaid for services they never provided.

Toshirea Jackson of Bridgeport has pleaded guilty in Bridgeport district court to one count of healthcare fraud for participating in a scheme involving two businesses she co-owned in Connecticut.

Beginning in 2012, Jackson and Juliet Jacob operated Transitional Development and Training and It Takes A Promise in Bridgeport, which provided social and psychotherapy services.

U.S. Attorney John Durham said that an investigation into the two businesses found that the two billed Medicaid for services that were never provided. As part of the scheme, Jackson and Jacob used the Medicaid provider numbers of two licensed health care providers who had neither rendered nor supervised any of the psychotherapy services that Jackson and Jacob billed to Medicaid, he said.

"The investigation further revealed that, in March 2012, Nikkita Chesney, who was employed by a health care provider that provided substance abuse treatment, including a detoxification program in Bridgeport, began to steal the personal identification information of Medicaid clients who were patients of her

employer," Durham noted. "The personal identifying information included the patients' Medicaid identification number, Social Security Numbers and dates of birth."

In total, Jackson, admitted to stealing the identities of more than 150 Medicaid clients, half of which were billed successfully.

Jackson, 49, remains released on a $25,000 bond. When she is sentenced, she will face a decade in prison and has agreed to pay $2,496,618 in restitution. No return court date has been announced. In October, Jacob pleaded guilty to one count of health care fraud for her role in the scheme and a separate Medicaid fraud scheme. On Oct. 23, Chesney pleaded guilty to one count of health care fraud and one count of aggravated identity theft. Both await sentencing.

Durham noted that five others have been charged and convicted of health care fraud offenses as a result of this and related investigations.

Unlicensed dentist from N.J. convicted in $2M Medicaid fraud scheme

Posted December 11, 2018 at 11:43 AM

A Roselle man who worked as an unlicensed dentist in New York has been convicted of a healthcare fraud scheme that stole more than $2 million from taxpayer-funded insurance providers, federal authorities said Monday.

Luis Omar Vargas, 46, worked at Dental Express Broadway on 161st Street in Manhattan and helped recruit patients who received Medicaid and other taxpayer-funded health insurance plans, according to Geoffrey S. Berman, the United States Attorney for the Southern District of New York.

Once a patient came to the office, Vargas would perform minor dental procedures. The patients were then paid $25 cash for the visit by the office receptionist, identified in court documents as 60-year-old Anna Jones. Dental Express Broadway later billed the insurance companies for dental work that was never performed.

In some cases, the patients were told to recruit others who received Medicaid, according to a complaint filed in the Southern District of New York.

"Vargas and others induced patients to be seen at (the dental office) by offering patients a $25 cash kickback," Berman said. "Once the patients were in the door, Vargas and his co-conspirators charged insurance companies for services that were never performed and for services performed by Vargas that he was not licensed to perform."

The scam went on for about six years, ending in November 2017 when Vargas, Jones and Mehmet Dikengil were arrested in New York and New Jersey on healthcare fraud charges.

Dikengil, 70, was a licensed dentist who provided the $25 kickback to patients in envelopes he gave to Jones, according to the complaint.

After a two-week trial that ended Friday, Vargas was convicted of healthcare fraud, conspiracy to commit healthcare fraud and conspiracy to violate the federal Anti-Kickback Statute. He faces a possible sentence of 25 years in prison.

Sentencing was set for April 5, 2019. Dikengil and Jones previously pleaded guilty to fraud charges, the U.S. Attorney said.

Dearborn entrepreneur charged in $1M health care fraud

Robert Snell, The Detroit News Published 1:46 p.m. ET Dec. 31, 2018 | Updated 2:49 p.m. ET Dec. 31, 2018

Haytham "Tom" Fakih(Photo: Facebook)

A Dearborn pharmacist, hailed earlier this year for opening the nation's first halal-certified Sonic Drive-In restaurant, cheated Medicare and Medicaid by charging for medication prescribed to dead people, according to federal prosecutors.

Trudell Pharmacy owner Haytham "Tom" Fakih also committed health care fraud by billing for expensive medication that was not dispensed to patients, prosecutors alleged in a criminal complaint filed against the pharmacist in federal court Sunday. In all, the fraud cost more than $1.2 million, authorities allege.

Fakih, 53, is the latest in a string of local doctors, businessmen and medical professionals facing criminal charges related to health care fraud that have totaled more than $800 million in recent years.

The investigation emerged publicly in September when federal agents seized more than $350,000 during a series of raids that happened five months after Fakih staged a ribbon-cutting ceremony at his Sonic Drive-In restaurant with Dearborn Mayor John O'Reilly Jr. and other community leaders.

On Sunday, Fakih was released on $10,000 unsecured bond after making an initial appearance in federal court. If convicted, he could spend up to 10 years in prison.

Doctors flee country amid fraud, opioid crackdown

Neither Fakih nor his attorney could not be reached for comment Monday.

The fraud outlined by prosecutors dates to 2012. Investigators allege Fakih, while owning the pharmacy on Schaefer Road, north of Ford Road, fraudulently billed Medicare and Medicaid for medications that were not given to patients, according to the criminal complaint.

Trudell Pharmacy in Dearborn, which Haytham "Tom" Fakih founded in 1996. (Photo: City of Dearborn)

"Fakih submitted false and fraudulent claims, through interstate wires from Michigan, to Medicare and Medicaid," Michael Pemberton, a special agent with

the U.S. Department of Health and Human Services, wrote in the complaint.

The list of drugs included medication used to treat asthma, acid reflux, arthritis, shingles and bipolar disorder.

"Based upon the shortage detected ... Medicare and Medicaid paid Trudell approximately $1,239,577.57 for medications that Trudell did not have sufficient inventory to dispense," the federal agent wrote.

The investigation intensified on Sept. 11.

That's when FBI agents seized cash from multiple bank accounts tied to Fakih and the entrepreneur's Dearborn Heights home, according to a government notice. The seizures included $181,725 found at his home and inside his 2015 Lexus.

Agents also seized $18,583 from a bank account belonging to South Ford Road Investments LLC. The company owns the Sonic Drive-In restaurant property, according to Dearborn records.

> *Visit the Sonic Drive In new to Dearborn! Choose drive in, dine in or carry out service. Halal options available. #dearborn#detroit#sonic#metrodetroit#SonicDriveIn#Sonicpic.twitter.com/qlzXpwDFvT*
>
> *— City of Dearborn MI (@cityofdearborn) April 26, 2018*

Fakih drew attention in April when the Sonic Drive-In debuted, becoming the chain's first location nationwide to offer food prepared according to Islamic law.

rsnell@detroitnews.com

(313) 222-2486

Twitter: @robertsnellnews

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.

SourceURL: https://revcycleintelligence.com/news/medicare-medicaid-exclude-200-more-docs-for-healthcare-fraud

Medicare, Medicaid Exclude 200% More Docs for Healthcare Fraud

The number of physicians excluded from Medicare, Medicaid, and other public healthcare programs increased 20 percent each year from 2007 to 2017.

By Jacqueline LaPointe

December 18, 2018 - Efforts to combat healthcare fraud, waste, abuse by Medicare, Medicaid, and public insurance programs may be paying off, according to a new study from the University of Southern California and Harvard Medical School.

The study recently published in *JAMA Network Open* revealed that the number of physicians excluded from Medicare, Medicaid, and other public healthcare programs increased by about 200 percent from 2007 to 2017. The physicians had to exit the programs because of healthcare fraud schemes, health crimes, or unlawful prescribing of controlled substances.

The trio of researchers also found that excluded physicians during the ten-year period were more likely to be male, older, not have a faculty appointment at a US medical school, and have graduated from osteopathic medical school or were an international medical graduate.

Additionally, Medicare and state public insurance programs excluded more practicing family medicine physicians, psychiatrists, internal medicine providers, anesthesiologists, surgeons, and OBGYNs during the period.

Researchers from the University of Southern California and Harvard Medical School hope their findings can support and bolster healthcare fraud, waste, and abuse prevention efforts.

"Our results highlight the potential value of using physician characteristics, in conjunction with information on medical claims filed by physicians, to help identify adverse physician behavior," they wrote in the study. "In their predictive

models, Centers for Medicare & Medicaid Services already uses fee-for-service claims data to identify clinician behaviors that warrant administrative actions. However, some of these models have high false-positive rates and have led regulators to invest significant time and resources into investigations of physicians who are not engaged in untoward activities."

"Therefore, improving the sensitivity and specificity of these predictive models could increase the efficiency with which regulators allocate limited investigation and enforcement resources," they stressed.

Healthcare fraud, waste, and abuse is a multibillion-dollar problem for Medicare, Medicaid, and other public healthcare programs.

According to the latest date from the Institute of Medicine, healthcare fraud, waste, and abuse cost $750 billion, or 28 percent of total healthcare spending in 2009. And fraud alone represented about $75 billion of that wasteful spending.

The FBI also estimated fraudulent medical billing cost the industry up to $260 billion in 2010, or 10 percent of total healthcare spending.

Healthcare fraud, waste, and abuse continues to be a major problem for Medicare, Medicaid, and other public healthcare programs. In 2017 alone, federal healthcare fraud investigations and convictions returned about $2.6 billion in taxpayer dollars to public insurance programs.

HHS OIG and the Department of Justice also charged over 600 individuals involved in healthcare fraud schemes in 2018, representing the largest healthcare fraud takedown to date.

In light of the costly problem, Medicare, Medicaid, and public healthcare programs have implemented strategies to combat and prevent healthcare fraud, waste, and abuse over the last couple of years. For example, the Affordable Care Act allocated $350 million starting in 2011 to the Health Care Fraud and Abuse Account department at HHS and boosted sanctions on providers who may have committed healthcare fraud, waste, or abuse.

Medicaid programs also received the authority to halt payments to questionable providers and recoup overpayments within 60 days, rather than three years.

The federal and state efforts to combat healthcare fraud, waste, and abuse may be working, the study suggested. The number of physicians excluded from

Medicare, Medicaid, and other public healthcare programs increased on average by 20 percent per year from 2007 to 2017, researchers reported.

The number of physician exclusions may be rising due to prevention and combat efforts, they explained.

"[T]his finding could be evidence that regulators, who have been aided by recent public policies targeting the reduction of fraud and waste, may be getting better at identifying perpetrators of fraudulent activity," the report stated.

A predictive analytics tool launched by Medicare in 2011 also helped to identify physicians engaging in illegal or questionable billing, potentially resulting in enhanced prevention. Notably, the tool saved $1.5 billion in 2016 by proactively detecting fraudulent claims and improper Medicare payments before the claims were paid to providers.

"This combination of increased funding for identifying and preventing health care fraud, harsher sanctions for potential perpetrators of fraud, and new tools for identifying fraud may have helped regulators to identify greater numbers of physicians engaging in fraudulent activity," the report stated.

Researchers intend for their findings to enhance federal and state efforts to prevent healthcare fraud, waste, and abuse. The physician characteristic data should help predictive analytics tool to better identify physicians at risk for healthcare fraud, abuse, and waste.

Former NCSU booster gets 18 months in prison for Medicaid fraud

Posted December 6, 2018

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.

Maryland health care aide charged with Medicaid fraud of almost $450K

by Diana DiGangi/ABC7

File photo

WASHINGTON (ABC7) —
A Laurel woman was arrested last Thursday on charges of defrauding D.C.'s Medicaid program for payments totaling around $434,000 from 2014 to 2017, the Department of Justice said.

Mobolaji Tina Stewart, 57, caught the attention of the District's Medicaid agency when she was identified as the second-highest paid personal care aide in 2014 and 2015.

Stewart has been charged with health care fraud and making false health care statements. Her arrest documents make several allegations of fraud, including a claim that Stewart was billing Medicaid for more than 24 hours in a day.

Waterbury woman charged with Medicaid fraud

Republican-American

December 26, 2018

WATERBURY — A home healthcare worker was arrested Wednesday in connection with an alleged Medicaid scheme.

Authorities say 36-year-old Nicole Feliciano, of Waterbury, submitted fraudulent bills for in-home care she didn't actually provide.

Feliciano was charged by inspectors from the Medicaid Fraud Control Unit in the Office of the Chief State's Attorney with first-degree larceny by defrauding a public community and health insurance fraud.

The thefts occurred between January 2014 and April 2016. Authorities say she claimed to perform the work for a disabled client who was not home, but in a hospital or nursing home.

Feliciano pocketed about $2,940 for the fraudulent claims, according to arrest warrant.

Feliciano was employed under the Personal Care Assistance program, which is a federal and state funded Medicaid program that provides funds to allow disabled adults to hire assistants for daily care. The program allows clients to remain at home instead of being placed in a facility.

The state Department of Social Services, which administers the state's PCA contracts, uncovered the alleged scheme after finding the disabled client was not living at home for some periods of time that were billed, authorities say.

Feliciano's bond was set at $10,000. She is scheduled to appear in Hartford Superior Court on Jan. 11.

Alaska woman sentenced to probation for Medicaid fraud

Originally published January 1, 2019 at 8:04 pm

By
The Associated Press

The Associated Press

FAIRBANKS, Alaska (AP) — A former personal care attendant in Alaska has been sentenced to three years of probation for fraudulently billing more than $50,000 to Medicaid.

The Fairbanks Daily News-Miner reports 57-year-old Sirje Kulakevich was sentenced last week in Fairbanks Superior Court after pleading guilty to one count of felony medical assistance fraud.

Kulakevich was employed with Alaska Home Care in Delta Junction from 2010 to 2016.

According to court documents, she took lengthy absences from work but was still paid after submitting time sheets and notes on the conditions of her clients.

Kulakevich was ordered to pay back the money and perform 72 hours of community service.

A judge could sentence her to up to 18 months in prison if she fails to meet the conditions of her probation.

___

Information from: Fairbanks (Alaska) Daily News-Miner, http://www.newsminer.com

Aurora Health Care Pays $12M to Settle Healthcare Fraud Claims

The Wisconsin-based health system settled healthcare fraud and abuse allegations stemming from compensation arrangements with two physicians.

Source: Thinkstock

By Jacqueline LaPointe

December 13, 2018 - An integrated health system that services patients in Wisconsin, Illinois, and Michigan recently agreed to pay $12 million to federal and state governments to settle healthcare fraud allegations.

According to an announcement from the US Attorney's Office in the eastern district of Wisconsin, Aurora Health Care settled claims that the health system violated the Stark Law by entering compensation arrangements with two physicians that exceeded fair market value.

The Stark Law is a set of federal healthcare fraud and abuse laws that prohibit physician-self referral. In other words, the Stark Law forbids physicians from referring patients for designated healthcare services paid for by public healthcare

programs to any entity with whom they have a financial relationship. Financial relationships include direct or indirect ownership or investment interest by the referring physician, as well as any financial interest held by any of the physician's immediate family members, law firm Barrett and Singal explain.

The US Attorney's Office added in the announcement that "such financial relationships can compromise the physicians' professional judgment."

The US federal government and the State of Wisconsin alleged that Aurora did not comply with the Stark Law during certain periods from 2008 to 2012. During those periods, the health system reportedly entered compensation arrangements that "were not commercially reasonable and because the compensation exceeded the fair market value of the physicians' services, took into account the physicians' anticipated referrals, and was not for identifiable services."

Aurora is a non-profit health system employing 33,000 caregivers, including 1,800 physicians, across 15 hospitals and more than 150 clinics across three states. The health system brought in about $5.1 billion in annual revenue.

The health system also potentially violated the False Claims Act, the US Attorney's Office stated.

The False Claims Act prohibits providers from knowingly filing claims for payments that violate Medicare's or Medicaid's rules. For example, submitting claims for services that violated the Stark Law are considered false claims under the act.

Aurora allegedly submitted claims for the physicians with whom the health system had an improper financial relationship. Therefore, the health system also violated the False Claims Act, the US Attorney's Office reported.

"Each year, Federal and State governments spend over a trillion dollars on healthcare programs like Medicare and Medicaid," said United States Attorney Krueger. "This settlement reflects the US Department of Justice's commitment to using all available legal tools to ensure those healthcare dollars are spent wisely."

The Justice Department and other federal agencies are committed to cracking down on healthcare fraud and abuse. For example, HHS alongside the Justice Department and the Office of the Inspector General charged over 600 individuals in 2018 with healthcare fraud and abuse crimes. In the largest healthcare fraud

takedown to date, the agencies caught individuals involved in schemes that defrauded Medicare and Medicaid of over $2 billion.

HHS and the Justice Department also reported in April 2018 that their agencies recovered about $2.6 billion in taxpayers dollars in the 2017 fiscal year because of its healthcare fraud and abuse efforts. The agencies recouped billions in dollars using legal action to take down criminals and data analytics to identify improper payments.

Healthcare providers should anticipate the agencies to continue their crackdown on healthcare fraud and abuse as the rate of healthcare costs continue to rise. Healthcare costs increased 3.9 percent in 2017, accounting for $3.5 trillion that year, CMS actuaries recently reported.

Reducing healthcare costs is a top priority for federal and state governments. And ensuring government payers properly reimburse providers for services rendered is key to lowering unnecessary healthcare spending

SourceURL: https://www.tennessean.com/story/news/crime/2018/12/14/fishield-behavorial-medical-services-fraud-margaret-fisher-charged-forgery-identity-theft-medicare/2316921002/

Nashville CEO forged signatures for fake therapy, U.S. Attorney says

Mariah Timms, Nashville Tennessean Published 5:42 p.m. CT Dec. 14, 2018
Medicare fraud: Former CEO forged signatures for fake services Mariah Timms, USA Today Network-Tennessee

The former CEO of Nashville's now-defunct Fishfield Behavioral Medical Services, Inc. was been charged with healthcare fraud after investigators say Margaret Fisher forged a therapist's signatures on insurance claims.(Photo: USA TODAY Handout)

A former Nashville CEO was arrested in North Dakota this week after investigators say she stole more than $1 million from Medicare and Medicaid.

Margaret Fisher, 60, used to be the CEO of Fishield Behavioral Medical Services, Inc. in Madison.

While there, Fisher regularly submitted false claims to Medicare and Medicaid, the U.S. Attorney's office said.

Forging signatures

She allegedly "represented that Fishield patients received psychotherapy services" — except the psychotherapist says that never happened. The healthcare provider was not named in the release from the U.S. Attorney's office.

In total, the fraudulent claims brought more than $1 million into Fisher's hands, according to investigators.

To make them seem legitimate, Fisher would forge (or possibly tell someone else to forge) the healthcare provider's signature on the forms, investigators say.

No response from company

A number posted online for Fishield was not in service on Friday afternoon, the company's Facebook page had not been active since January 2017 and the company's website led to an error page.

Fisher was indicted on charges of healthcare fraud and aggravated identity theft in November. She was arrested in North Dakota by U.S. Marshals on Thursday.

Prison time possible

If she is convicted, Fisher faces a sentence of up to 10 years in prison on the healthcare fraud charges and an additional mandatory two-year sentence on the aggravated identity theft charges.

Additionally, each count could require a $250,000 fine, and she would have to forfeit any property derived from the alleged criminal activity.

The case was investigated by the U.S. Department of Health and Human Services and the Tennessee Bureau of Investigation.

Reach Mariah Timms at mtimms@tennessean.com or 615-259-8344 and on Twitter @MariahTimms.

SourceURL: https://www.brownsvilleherald.com/news/valley/operator-of-medical-equipment-company-sentenced-on-fraud-charges/article_368c4bd0-03e7-11e9-8f78-5f6b53a7dca6.html

Operator of medical equipment company sentenced on fraud charges

Docs: Man defrauded Medicaid program of more than $1.5M

MGN Online

Posted: Wednesday, December 19, 2018 9:30 pm

Operator of medical equipment company sentenced on fraud charges

BY LORENZO ZAZUETA-CASTRO STAFF WRITER Brownsville Herald

McALLEN — The operator of a local durable medical equipment company was sentenced to three years in prison Wednesday, court documents show.

George Louis Moreno, operator of Mars DME Inc., stood before U.S. District Judge Micaela Alvarez Wednesday morning during a scheduled sentencing hearing related to federal healthcare fraud allegations.

Moreno, who pleaded guilty in January to one count of healthcare fraud, will serve a three-year sentence in connection with a federal investigation that revealed he defrauded the Texas Medical Assistance Program, also known as the Texas Medicaid program, of more than $1.5 million.

According to a four-page federal criminal complaint filed against him last December, Moreno was accused of submitting claims for incontinence supplies that either were not delivered, or delivered for a higher value.

Government prosecutors alleged that Moreno and others conspired to defraud the medical assistance program using "fraudulent pretenses."

Moreno ran a scheme over the course of nearly eight years by submitting false claims through the program.

According to the Texas Secretary of State website, Mars DME Inc., which first filed as a business in the state in 2005, is no longer active as of January 2016 due to non-payment of taxes.

The complaint stated that between August 2008 and January 2016, Moreno attempted to profit from the scheme by submitting or causing others to submit false and fraudulent claims to Texas Medicaid.

The document further stated that Moreno, "in order to execute and carry out the illegal activities," submitted or caused others to submit fake claims for reimbursement of incontinence supplies that were not actually provided or only "partially delivered" to patients and clients.

Moreno also submitted false claims to Texas Medicaid asking for reimbursements for higher valued incontinence supplies, "when lower-reimbursing supplies were actually delivered to beneficiaries," the document stated.

What's more, Moreno caused others to make cash payments to beneficiaries instead of delivering the incontinence supplies, court documents show.

The government believes that over the course of the nearly eight years, Moreno caused Texas Medicaid to make overpayments of approximately $1,564,118.68.

As part of his punishment, Moreno will be required to pay back $1,491,399.78 in restitution, and serve three years of supervised release upon completion of his prison term.

Prior to his sentencing, Moreno was free on a $100,000 bond, and will remain on bond until he is required to surrender for prison Jan. 2, 2019.

lzazueta@themonitor.com