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Medicaid Fraud Curator

Week of March 4th , 2019

Woman pleads guilty to Medicaid fraud totally almost $31,000

SourceURL: https://www.delmarvanow.com/story/news/local/virginia/2019/03/04/medicaid-fraud-virginia-woman-pleads-guilty/3029157002/

Woman pleads guilty to Medicaid fraud totally almost $31,000

A woman who submitted false time sheets to Medicaid for work she did not perform pleaded guilty to fraud and other charges in Northampton County court.

Pauline Bailey, 57, of Machipongo, who was in court Feb. 25 to face six felony charges, pleaded guilty to Medicaid fraud, conspiracy to make false statements to obtain money and obtaining money by false pretenses.

Under a plea agreement, the commonwealth dropped three of the six charges related to the offenses dating to 2014.

According to court testimony, Bailey submitted fraudulent time sheets in the amount of $30,959.08 for work that was never performed over the course of two years.

She was indicted on the charges in March 2018 and the case was prosecuted in Northampton County by Assistant Attorney General John W. Trent of Richmond.

Trent said Bailey was paid to perform care for an indigent person.

He told the court Bailey was paid by the Department of Medical Assistant Services for performing personal care, hygiene and light housekeeping for the patient.

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“She knew she was not entitled to the money and did not perform the services,” said Trent.

The terms of the plea agreement included a 10-year period to repay the money, and that she is not to participate in the federal health care system for 10 years and to be on supervised probation. The agreement does not contain a recommendation for a sentence.

Judge W. Revell Lewis III accepted the agreement and ordered that a criminal history and sentencing guidelines be prepared.

He allowed Bailey to remain on bond until her May 20 sentencing.

Prestonsburg woman sentenced in state Medicaid fraud case - ABC 36 News

SourceURL: https://www.wtvq.com/2019/03/05/prestonsburg-woman-sentenced-ordered-repay-state-medicaid-program/

Prestonsburg woman sentenced in state Medicaid fraud case

March 5, 2019

FRANKFORT, Ky. (WTVQ) –A Prestonsburg woman was sentenced and ordered to repay the state Medicaid program more than $12,000 after pleading guilty to theft charges and engaging in a scheme to defraud the program, according to the state attorney general's office.

Investgators say 34-year old Amy Slone, of Prestonsburg, a former employee at Minix Eye Care, PSC, entered a guilty plea in December of 2018, to one count of theft by unlawful taking over $10,000 and one count of devising or engaging in a scheme to defraud the Kentucky Medical Assistance Program of $300 or more.

It is alleged that while employed at Minix Eye Care, PSC, Slone, along with her co-defendant Marcus S. Minix, billed Kentucky Medicaid for services that were not provided. They received over $10,000 from Kentucky Medicaid as a result of the fraudulent billing, according to investigators.

Slone was sentenced on March 1, 2019 in Franklin Circuit Court to a seven-year sentence that was probated, according to prosecutors.

Marcus Minix's case is still pending and he has entered a plea of not guilty.

Related Article: Ex-Kentucky officer pleads guilty to sexually abusing minors

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Former MDHHS employee charged with Medicaid fraud

SourceURL: https://fox17online.com/2019/02/28/former-mdhhs-employee-charged-with-medicaid-fraud/

Former MDHHS employee charged with Medicaid fraud

Posted 6:22 PM, February 28, 2019, by FOX 17 News

LANSING, Mich. — A former Michigan Department of Health and Human Services employee is facing felony fraud charges.

Eliza Ijames, 56, is charged with one count of conspiracy to commit Medicaid fraud and two counts of receiving kickbacks from Medicaid fraud.

The conspiracy charge carries a maximum penalty of 10 years in prison and a $50,000 fine, and the fraud charges carry a maximum of four years in prison and a $50,000 fine.

Ijames is accused of referring clients to agencies she had a personal and financial relationship with and approving payments to them. Representatives from those agencies would allegedly deposit money into bank accounts owned in part by Ijames.

An MDHHS release said Ijames withdrew nearly $200,000 from those accounts for personal use between January 2015 and December 2017.

Kansas City pharmacist pleads guilty in scam to get thousands from Medicaid

SourceURL: https://www.kansascity.com/news/local/crime/article226984209.html

Kansas City pharmacist pleads guilty in scam to get thousands from Medicaid

By Laura Bauer

March 01, 2019 04:12 PM,

Updated March 01, 2019 08:33 PM
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Pharmacy must pay $9.5 million for prescription fraud

A small pharmacy based in Overland Park will pay $9.5 million to settle a federal health care fraud lawsuit, and a Lenexa pharmacist will get $1.5 million of that for blowing the whistle on her former employer.

A Kansas City pharmacist pleaded guilty Friday to bilking Medicaid out of tens of thousands of dollars, federal prosecutors say.

Steven Baraban, the former director and managing partner of Stark Pharmacy, was charged with one count of health care fraud, a felony that could mean up to 10 years in prison and a $250,000 fine.

Baraban supervised operations at the pharmacy location inside Research Medical Center on Holmes Road.

According to court documents, Medicaid paid him for pain creams as wells as an antibiotic used to treat bacterial infections, though patients never received those products.

"Baraban knew, or should have known, that Medicaid was being billed by Stark Pharmacy for medications that it did not take appropriate steps to deliver," read the charge filed in U.S. District Court. "Baraban and Stark Pharmacy financially benefited by billing, and being paid by, Medicaid for medications for which there was no attempt to deliver them to Medicaid beneficiaries."

The charges against Baraban come after the pharmacy settled a federal health care fraud lawsuit for $9.5 million in December. A portion of that money — $1.5 million — went to a former employee who blew the whistle on the pharmacy.

Emily Barnes, a Lenexa pharmacist, worked at Stark in 2015 and quit after just five months. She reported that she witnessed numerous incidents of health care fraud, including auto-filling prescriptions for a certain pain cream without patients' consent and charging full price for prescriptions that were only partially filled.

The pharmacy's namesake, Howard Stark, is not affiliated with the business, having sold it in 2000. He said that as a past president of the American College of Apothecaries, he was disappointed to see his name involved.

In addition, the pharmacy is not affiliated with the hospitals where it operates — Research's Brookside campus and Menorah Medical Center in Overland Park.

In the latest case, according to court records, Stark Pharmacy billed Medicaid for nearly $120,000 for compound pain creams that were intended for Medicaid patients.

"Medicaid would not have paid those claims if it had known that Stark Pharmacy did not take appropriate steps to deliver those medications and maintain appropriate proof of its efforts of delivery," court records said.

In June 2016, the Stark location at Research filled a prescription for Zyvox for someone on Medicaid. Medicaid reimbursed the pharmacy $5,162, but then Stark sent the medication back to the wholesaler and kept the refund, records show.

Baraban will have to forfeit any property and funds “derived, directly or indirectly, from gross proceeds traceable” to the fraud. That also includes $125,000 in cash.

Former Stark Pharmacy director pleads guilty to healthcare fraud: A former director and managing partner of Stark Pharmacy, based in Overland Park, Kan., pleaded guilty March 1 to billing Medicaid tens of thousands of dollars for medications that patients

SourceURL: https://www.beckershospitalreview.com/legal-regulatory-issues/former-stark-pharmacy-director-pleads-guilty-to-healthcare-fraud.html

Former Stark Pharmacy director pleads guilty to healthcare fraud

Alia Paavola - 22 hours ago Print | Email

A former director and managing partner of Stark Pharmacy, based in Overland Park, Kan., pleaded guilty March 1 to billing Medicaid tens of thousands of dollars for medications that patients never received, according to *The Kansas City Star.*

Steven Baraban pleaded guilty to one count of healthcare fraud, a felony that has a prison sentence of up to 10 years. He was fined $250,000.

Prosecutors said Medicaid paid him for pain creams and antibiotics that patients never received. The guilty plea comes after Stark Pharmacy settled a federal healthcare fraud lawsuit for $9.5 million.

"[Mr.] Baraban knew, or should have known, that Medicaid was being billed by Stark Pharmacy for medications that it did not take appropriate steps to deliver," TheStar reported. "Baraban and Stark Pharmacy financially benefited by billing, and being paid by, Medicaid for medications for which there was no attempt to deliver them to Medicaid beneficiaries."

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Kansas City pharmacist pleads guilty to Medicaid fraud

Kansas City pharmacist pleads guilty to Medicaid fraud

The Associated Press

March 02, 2019 11:58 AM,

Updated March 02, 2019 11:59 AM
KANSAS CITY, Mo.
A Kansas City pharmacist has pleaded guilty to bilking Medicaid out of tens of thousands of dollars.

The Kansas City Star reports that Steven Baraban, the former director and managing partner of Stark Pharmacy, pleaded guilty Friday to one count of health care fraud. He could face up to 10 years in prison when he's sentenced.

Baraban supervised operations at the pharmacy location inside Research Medical Center. Prosecutors say Baraban will have to forfeit $125,000 in cash and any property derived from the fraud.

Prosecutors say Medicaid paid Baraban for pain creams and an antibiotic that patients never received.

Idaho Woman Sentenced for Medicaid Provider Fraud

SourceURL: http://newsradio1310.com/idaho-woman-sentenced-for-medicaid-provider-fraud/

Idaho Woman Sentenced for Medicaid Provider Fraud

Getty Images/iStockphoto
BOISE, Idaho (KLIX) – A Boise woman has been sentenced after pleading guilty to Medicaid provider fraud.

Kimberley A. Reed, 51, pleaded guilty in January and on Friday received a two-year unified sentence, according to Idaho Attorney General Lawrence Wasden. Fourth District Court Judge Jason Scott then suspended the sentence and ordered Reed to complete two years of probation.

According to information from Wasden's office, Reed, a care provider, submitted progress reports detailing personal care services provided to a client in June 2015. Investigators later determined the client was incarcerated in the Ada County Jail when Reed claimed to have administered care.

"The false reports were later used as the basis for fraudulent Medicaid billings," the news release explained.

As part of her sentence, Reed also must serve 75 days in jail and 30 days of discretionary jail. The court also ordered her to serve 150 hours of community service and pay $1,905 in restitution to Living Independence Network Corp., as well as court costs.

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ATTORNEY'S OFFICE OF TEXAS: Two RGV Residents Indicted for Health Care Fraud

SourceURL: https://setexasrecord.com/stories/512078443-attorney-s-office-of-texas-two-rgv-residents-indicted-for-health-care-fraud

ATTORNEY'S OFFICE OF TEXAS: Two RGV Residents Indicted for Health Care Fraud

By **Press release submission** | Mar 5, 2019

U.S. Attorney's Office for the Southern District of Texas issued the following announcement on Feb. 28.

Two Rio Grande Valley residents have been taken into custody for submitting fraudulent claims for payment to Texas Medicaid for durable medical equipment (DME) supplies that were never delivered to Medicaid beneficiaries, announced U.S. Attorney Ryan K. Patrick.

A federal grand jury in McAllen returned the indictment Feb. 26, 2019, against Everardo Villarreal, 46, of Edinburg, and Delilah Rae Robles, 38, of Weslaco. It was unsealed as they were taken into custody. They are expected to make initial appearances before U.S. Magistrate Judge Scott Hacker on Friday, March 1, 2019.

According to the indictment, Villarreal was the owner and operator of now defunct Durable Medical Supply Depot of Elsa. Robles was his secretary and Medicaid biller.

The indictment alleges they committed one count of conspiracy to commit health care fraud, four counts of substantive health care fraud as well as two counts of aggravated identity theft of local Medicaid beneficiaries' personal Medicaid numbers.

From on or about April 2010 to on or about September 2014, Villarreal and Robles allegedly billed Texas Medicaid in excess of $850,000 for DME that was either never delivered or was only partially delivered to Medicaid beneficiaries. The indictment alleges Villarreal and Robles purchased or arranged for the

purchase of personal Medicaid identification numbers of local Medicaid beneficiaries in order to submit false and fraudulent claims to Medicaid for items that were never intended to be delivered.

Each of the counts of health care fraud related matters carries a maximum of 10 years in federal prison. If convicted of identity theft, they each also face a mandatory two years imprisonment which must be served consecutively to any other sentence imposed. All of the charges also carry a $250,000 maximum possible fine.

Original source can be found here.

Healthcare fraud suspects appear in court; accused of billing Medicaid $1.5M - The Monitor

SourceURL: https://www.themonitor.com/2019/03/01/healthcare-fraud-suspects-appear-court-accused-billing-medicaid-1-5m/

Healthcare fraud suspects appear in court; accused of billing Medicaid $1.5M

March 1, 2019

Everardo Villarreal

McALLEN — The owner and an employee of a now-closed durable medical equipment, or DME business each made their first appearance before a federal magistrate judge in connection with healthcare fraud charges.

Standing before U.S. Magistrate J. Scott Hacker a day after federal agents made their arrest, Everardo Villarreal and Delilah Rae Robles each learned of the seven charges against them in connection with a scheme that allegedly defrauded a federal and state healthcare benefit program of more than $850,000 — this after submitting more than $1.5 million in claims.

During their respective appearances Friday morning before Hacker, both Villarreal, 46, and Robles, 38, the two said they would each seek to retain their own respective attorney, court notes show.

According to the eight-page unsealed indictment, Villarreal, owner of the now-shuttered Elsa-based DME Medical Supply Depot, and Robles, who Villarreal employed as his secretary, conspired to defraud Texas Medicaid by submitting fake claims in an effort to "unlawfully enrich" themselves.

Government prosecutors allege that the scheme, which began sometime in April 2010, and ended more than four years later in September 2014, was executed by

Villarreal and Robles “by submitting or causing others to submit false and fraudulent claims to Medicaid,” the record show.

In some instances, Villarreal allegedly paid kickbacks to an unnamed co-conspirator, referred to in the indictment by the initials “B.D.,” the document shows.

Delilah Robles

Villarreal, a native of Edinburg, paid B.D. kickbacks in the form of checks in exchange for patient information — specifically the names and personal identification numbers of Medicaid beneficiaries.

“As part of the kickback arrangement between Villarreal and B.D., B.D. bought back incontinence supplies from certain Medicaid beneficiaries whose patient information Villarreal purchased from B.D.,” the indictment states. “Villarreal used the patient information purchased from B.D. to submit or cause others to submit false and fraudulent claims to Medicaid in order to cause Medicaid to render payment.”

In addition, Villarreal instructed Robles, of Weslaco, to bill Medicaid for supplies that had not been delivered to Medicaid beneficiaries.

“Robles coordinated with B.D. to supply patient information to Villarreal in exchange for kickback payments from Villarreal,” the document states. “The defendants and their co-conspirators offered to pay cash to Medicaid beneficiaries in exchange for supplies.”

In all government prosecutors allege the pair submitted “in excess of $1,500,000 in claims to Medicaid,” and for which Medicaid paid in excess of $850,000 in false and fraudulent claims.

The government is also seeking to seize “all property, real or personal,” and a monetary judgment against the defendants.

The pair faces seven charges, including one count of conspiracy to commit healthcare fraud, four counts of healthcare fraud, and two counts of aggravated identity theft, the indictment stated.

Both will be back before Hacker on March 5 for their respective detention hearings where they could potentially be released on bond.

If convicted, the Valley residents could face up to 10 years in federal prison; and if convicted of identity theft, they each also face a mandatory two years in prison, which must be served consecutively to any other sentence imposed. The charges also carry a $250,000 maximum possible fine.

Report: Former Crestview Manor employee arrested for exploiting hospice patient

SourceURL: https://weartv.com/news/local/report-crestview-manor-employee-arrested-for-exploiting-hospice-patient

Report: Former Crestview Manor employee arrested for exploiting hospice patient

by Digital Staff

Tuesday, March 5th 2019

Report: Crestview Manor employee arrested for exploiting hospice patient

OKALOOSA COUNTY, Fla. (WEAR) — A 31-year-old man who worked at Crestview Manor has been arrested for exploitation of an elderly hospice patient.

An affidavit states Devario Glass told a patient he needed $500 for a car, so the hospice patient signed a check Glass wrote.

Records state Glass asked employees at Crestview Manor to help him cash the check, instead they reported the incident(s).

According to the affidavit, Glass told the hospice patient he needed another $500 because the other check was not enough.

Documents show Glass saw a bank statement that showed the hospice patient had $15,000 and shared that with others at the health care facility.

Walton County Sheriff's Office and the Florida Attorney General's Medicaid Fraud Control Unit (MFCU) launched an investigation.

Glass was arrested on felony charges.

The MFCU "investigates fraud in the Medicare program" and Crestview Manor is a Medicaid receiving facility.