
Part III: Legal and Investigative Activities Related to Medicare and Medicaid

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NOTE: Summaries of OIG audit and evaluation reports in this publication contain rounded figures. Monetary amounts in case narratives are rounded to the next lower dollar, where appropriate.

Part III: Legal and Investigative Activities Related to Medicare and Medicaid

Medicare- and Medicaid-Related Outreach

As part of the Office of Inspector General's (OIG) continuing efforts to promote the highest level of ethical and lawful conduct by the health care industry, we issue advisory opinions and other guidance to educate industry and other stakeholders on how to avoid fraud, waste, and abuse.

Advisory Opinions

In accordance with section 205 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), OIG, in consultation with the Department of Justice (DOJ), issues advisory opinions to outside parties regarding the interpretation and applicability of certain statutes relating to Federal health care programs. This authority allows OIG to provide case-specific formal guidance on the application of the anti-kickback statute and safe harbor provisions and other OIG health care fraud and abuse sanctions. From April 1, 2010, through September 30, 2010, OIG received 19 advisory opinion requests and issued 11 advisory opinions. OIG advisory opinions are available at: <http://www.oig.hhs.gov/fraud/advisoryopinions.asp>.

Provider Self-Disclosure Protocol

OIG is committed to assisting health care providers and suppliers in detecting and preventing fraudulent and abusive practices. Since 1998, we have made available comprehensive guidelines describing the process for providers to voluntarily submit to OIG self-disclosures of fraud, waste, or abuse. The "Provider Self-Disclosure Protocol" gives providers an opportunity to minimize the potential costs and disruption that a full-scale OIG audit or investigation might entail if fraud is uncovered. In doing so, the self-disclosure also enables the provider to negotiate a fair monetary settlement and potentially avoid being excluded from participation in Federal health care programs. The protocol guides providers and suppliers through the process of structuring a disclosure to OIG about matters that constitute potential violations of Federal laws (as opposed to honest mistakes that may have resulted in overpayments). After making an initial disclosure, the provider or supplier is expected to thoroughly investigate the nature and cause of the matters uncovered and make a reliable assessment of their economic impact (e.g., an estimate of the losses to Federal health care programs). OIG evaluates the reported results of each internal investigation to determine the appropriate course of action.

In addition, OIG issued an Open Letter to Health Care Providers in 2006 to promote the use of the self-disclosure protocol to resolve civil monetary penalty (CMP) liability under the physician self-referral and anti-kickback statutes for financial arrangements between hospitals and physicians.

On April 15, 2008, OIG published another Open Letter to Health Care Providers. The letter sets forth certain refinements to the October 1998 Self-Disclosure Protocol. To improve the self-disclosure process, OIG, among other steps, streamlined its internal self-disclosure procedures. In addition, OIG explained that it will generally not require a self-disclosing entity to enter into a Corporate Integrity Agreement (CIA) or certification of compliance agreement (CCA) when a resolution has been negotiated pursuant to the protocol. A CIA is an agreement between the provider and OIG that is entered into in exchange for OIG's agreement not to seek an exclusion of that provider from participation in Medicare, Medicaid, and other Federal health care programs. CIAs are monitored by OIG and require providers to enhance existing compliance programs or establish new ones. The compliance programs are designed, in part, to prevent a recurrence of the underlying fraudulent conduct. OIG may also negotiate a CCA in lieu of a comprehensive CIA, under appropriate circumstances. The CCA requires that the provider maintain its existing compliance program and agree to certain compliance obligations that mirror those found in a comprehensive CIA.

OIG published its most recent Open Letter to Health Care Providers on March 24, 2009, that narrowed the scope of the self-disclosure protocol in regard to violations of the physician self-referral ("Stark") law and explained that OIG will no longer accept disclosure of a matter that involves only liability under the physician self-referral law in the absence of a colorable anti-kickback statute violation. The Open Letter also established a minimum settlement amount for anti-kickback disclosures of \$50,000.

The self-disclosure guidelines are available on the OIG Web site at <http://www.oig.hhs.gov/fraud/selfdisclosure.asp>.

See also:

Compliance Guidance: <http://www.oig.hhs.gov/fraud/complianceguidance.asp>

Open Letters: <http://www.oig.hhs.gov/fraud/openletters.asp>

During this reporting period, self-disclosure cases resulted in \$20 million in Department of Health & Human Services (HHS) receivables. The following are examples:

- **Massachusetts** – Elder Service Plan of the North Shore (ESPNS) and East Boston Neighborhood Health Center (EBNHC) agreed to pay \$308,709 and \$200,962, respectively, to resolve their Civil Monetary Penalties Law (CMPL) liability for contracting with an excluded dentist, Dr. Steven Ramos, for dental services that he provided to Medicare and Medicaid beneficiaries. Both parties had contracted with Dr. Ramos from May 2006 through February 2009. EBNHC self-disclosed to OIG that it had contracted with Dr. Ramos while he was excluded. During the course of investigating EBNHC's self-disclosure, OIG discovered that ESPNS also contracted with the excluded Dr. Ramos.
- **Colorado** – Colorado West HealthCare System (d/b/a/ Community Hospital) and its subsidiary, Doctors' Clinic Building, Inc., (collectively, "Colorado West") agreed to pay the United States \$420,175 in order to resolve their liability under the CMPL for conduct disclosed under the OIG's Self-Disclosure Protocol. In a total of 13 submissions between

September 2007 and March 2009, Colorado West disclosed that it had entered into six categories of contractual arrangements (i.e., medical director arrangements, emergency room services, office leases, on-call physician arrangements, continuing medical education services, and diagnostic test interpretations) that violated the Stark Law and, in some instances, potentially implicated the anti-kickback statute in connection with physicians' referrals of Medicare beneficiaries to Colorado West.

Office of Inspector General Administrative Sanctions

OIG has the authority to impose administrative sanctions for fraud or abuse or other activities that pose a risk to Federal health care programs and their beneficiaries (see Appendix E for an explanation of OIG's sanction authorities). These sanctions include the exclusion of individuals and entities from Federal health care programs and the imposition of CMPs for submitting false or fraudulent claims to a Federal health care program or for violating the anti-kickback statute, the Stark Law, or the "patient dumping" provision of the Social Security Act.

During this reporting period, OIG administered 1,446 sanctions in the form of program exclusions or administrative actions for alleged fraud or abuse or other activities that posed a risk to Federal health care programs and their beneficiaries.

Details and examples follow.

Program Exclusions

During this semiannual reporting period, OIG excluded 1,405 individuals and entities from Medicare, Medicaid, and other Federal health care programs. Most of the exclusions resulted from convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of license revocation. See <http://exclusions.oig.hhs.gov/>.

For example:

- **Maryland** – Physical therapist Marwan Khayat was excluded indefinitely based on the voluntary surrender of his physical therapy license to the Maryland Board of Physical Therapy Examiners. After the board initiated an investigation into Khayat's conduct, Khayat admitted to having a brief sexual relationship with a patient and engaging in inappropriate sexual contact with two female patients during treatment sessions.
- **Kansas** – Shelley Harding, a certified alcohol and drug abuse counselor, owner, and operator of a counseling center in Kansas, was excluded for a minimum of 30 years based on her health care fraud conviction. Between June 2001 and February 2006, Harding, doing business as A New Beginning, submitted materially false and fraudulent claims and caused others to submit materially false and fraudulent claims to Medicaid for community-based drug and alcohol abuse services for 81 children. Harding was sentenced to 24 months' incarceration and ordered to pay \$3,758,951 in restitution.
- **Idaho** – Dwight Manwaring was excluded for an indefinite period based on the voluntary surrender of his license to practice as a registered nurse in Idaho. While working as a nurse

in a nursing home, staff members observed Manwaring removing a Fentanyl patch from an 89-year old Alzheimer's patient. Fentanyl is a narcotic pain medication. A subsequent drug screen performed on Manwaring produced a positive result for Fentanyl.

- **Florida** – Manuel Casal, owner/operator of durable medical equipment (DME) company K.M. Medical Services, Inc., was excluded for a minimum of 50 years based on his conviction for health care fraud. Between June 2005 and December 2005, Casal billed Medicare for various health care benefits, items, and services that were not medically necessary or were not provided to beneficiaries. Casal was sentenced to 3 years and 10 months' incarceration and ordered to pay \$668,079 in restitution.
- **Texas** – James Chaney, a previous owner of a DME company, was excluded for a minimum of 25 years based on his conviction for aiding and abetting the unlawful obtaining of individually identifiable health information of an individual with the intent to sell, transfer, or use that health information for commercial advantage or personal gain. Over a 2-year period, Chaney purchased over 1,000 files from various DME companies that contained Medicare beneficiary information. He sold these beneficiaries' medical information to another owner of several DME companies, who used it to bill Medicare for DME that was not purchased by or delivered to beneficiaries. Chaney was sentenced to 60 months' incarceration and ordered to pay \$1,746,024 in restitution.

Civil Monetary Penalties Law

The CMPL authorizes OIG to impose administrative penalties and assessments against a person who, among other things, submits or causes to be submitted claims to a Federal health care program that the person knows or should know are false or fraudulent. During this reporting period, OIG concluded cases involving more than \$18.3 million in CMPs and assessments. The following are among the CMP actions resolved during this reporting period:

- **California** – Tenet Healthcare Corporation and Tenet HealthSystem KNC, Inc. (doing business as USC Norris Cancer Hospital) (collectively, "Tenet"), who are currently subject to a 5-year CIA with the OIG, agreed to pay \$1.9 million to resolve its liability under the CMPL. Tenet, pursuant to the CIA's Reportable Event disclosure requirements, revealed to OIG that between December 2003 and October 2007, it submitted claims not entitled to Federal health care program reimbursement for clinical research-related items or services rendered at USC Norris Cancer Hospital. Specifically, Tenet improperly received government reimbursement for: (1) items or services that were paid for by clinical research sponsors or grants under which the clinical research was conducted; (2) items or services intended to be free of charge in the research informed consent; (3) items or services that were for research purposes only and not for the clinical management of the patient; and/or (4) items or services that were otherwise not covered under the Centers for Medicare & Medicaid Services (CMS) Clinical Trial Policy.
- **Illinois** – United Shockwave Services, Ltd; United Urology Centers, LLC; and United Prostate Centers, LLC (collectively, United) agreed to pay \$7,359,500 and, along with United

Therapies, LLC, enter into a 5-year CIA to resolve their CMPL liability. United is a physician-owned enterprise that leases medical equipment and services for the treatment of kidney stones and enlarged prostate glands. The settlement resolves a number of allegations, including that United and certain physician-investors used their ability to control patient referrals to obtain contract business from hospitals in Illinois, Iowa, and Indiana. Specifically, OIG alleged that United threatened hospitals that it would refer patients to competing hospitals if they did not agree to a contract with United, or promised additional referrals to hospitals that did contract with United. Consequently, if hospitals chose to contract with United over competitors to get more referrals, all claims resulting from that relationship were prohibited by the anti-kickback statute. Furthermore, OIG alleged that certain physician-investor referrals to hospitals that had contracts with United also violated the Stark Law.

- **Massachusetts** – Robert J. Kramer and Kramer Physical Therapy Associates, Inc. (collectively, the “Respondents”) agreed to pay \$122,474 to resolve liability under the CMPL for allegedly submitting improper claims to Medicare from July 1, 2003, through June 30, 2006. Specifically, Respondents allegedly billed Medicare for physical therapy services that were not properly supervised by a licensed physical therapist as required by Medicare reimbursement rules. The Respondents previously entered into a settlement agreement with Massachusetts wherein they paid \$14,797 to resolve their liability for allegedly submitting the same type of improper claims to Medicaid during the same time period.
- **Missouri** – St. John’s Regional Medical Center (St. John’s) agreed to pay \$274,815 to resolve its CMPL liability in a self-disclosed improper financial relationship between a wholly owned subsidiary of St. John’s and a physician. OIG contended that the subsidiary allowed the physician, a referral source for St. John’s, to be regularly delinquent in rent under a written lease agreement in violation of the Stark Law and anti-kickback statute. St. John’s also allegedly paid the physician for services without a written contract in place.
- **North Dakota** – Lake Region Lutheran Home (d/b/a Heartland Center), a 98-bed skilled nursing facility (SNF), agreed to pay \$133,973 to OIG to resolve its CMPL liability for employing a licensed practical nurse who was excluded from all Federal health care programs between August 2002 and December 2005. A North Dakota Board of Nursing analyst referred the case to OIG’s Fargo, North Dakota, Field office.

Patient Dumping

Some of the CMP cases that OIG resolved between April 1 and September 30, 2010, were pursued under the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), a statute designed to ensure patient access to appropriate emergency medical services. The following are examples of settlements under this statute:

- **Alabama** – Providence Hospital paid \$45,000 to resolve allegations that it improperly refused to transfer a patient suffering an emergent gastrointestinal bleed. A 60-year-old man arrived at another hospital’s emergency department complaining of coffee-ground-like

vomit, severe abdominal pain, and dark-colored stools over the previous 12 hours. The hospital did not have the capacity or specialized services to treat him, so an attempt was made to transfer him to Providence Hospital. Providence refused the transfer request, even though it had the capacity and specialized capabilities to treat the patient. The refusal of the transfer request delayed care and treatment, and it took two more hours to transfer the patient to a more distant hospital. The patient's condition deteriorated, and he died later that day.

- **Illinois** – University of Chicago Medical Center paid \$50,000 to resolve allegations of patient dumping. A 78-year old man arrived at the emergency department by ambulance with his daughter. He was placed in the waiting room in full view of the staff. The medical center did not give the patient a medical examination during the three and three-quarter hours that he waited. The daughter then requested that her father be seen, at which point the staff discovered that the patient had died.

Criminal and Civil Enforcement

One of the most common types of fraud perpetrated against Medicare, Medicaid, and other Federal health care programs involves filing false claims for reimbursement. False claims may be pursued under Federal and State criminal statutes and, in appropriate cases, under the civil False Claims Act (FCA). A description of these enforcement authorities can be found in Appendix E.

The successful resolution of false claims often involves the combined investigative efforts and resources of OIG, the Federal Bureau of Investigation (FBI), Medicaid Fraud Control Units (MFCU), and other law enforcement agencies. OIG is responsible for assisting DOJ in bringing and settling cases under the FCA. Many providers elect to settle their cases prior to litigation. As part of their settlements, providers often agree to enter into CIAs with OIG to avoid exclusions from Medicare, Medicaid, and other Federal health care programs. Such agreements are monitored by OIG and require the providers to enhance existing compliance programs or establish new ones. The compliance programs are designed, in part, to prevent a recurrence of the underlying fraudulent conduct.

During fiscal year (FY) 2010, the Government's enforcement efforts resulted in 552 criminal actions and 371 civil actions against individuals or entities that engaged in health-care-related offenses. These efforts resulted in \$3.2 billion in HHS and \$570.2 million in non-HHS investigative receivables, including civil and administrative settlements or civil judgments related to Medicare; Medicaid; and other Federal, State, and private health care programs. Some of the notable enforcement actions, and other related activities, are described below. Summaries are organized by the sector of the health care industry involved or by the nature of the offense.

Special Assistant United States Attorney Program

DOJ and OIG launched a program in which OIG attorneys serve as Special Assistant United States Attorneys. OIG attorneys are detailed full-time to DOJ's Criminal Division, Fraud Section, for temporary assignments, such as with the Medicare Fraud Strike Force described below; others prosecute matters on a case-by-case basis. Both arrangements offer excellent litigation training for OIG attorneys and enhance collaboration between the departments in fighting fraud. Under this program, OIG attorneys have successfully litigated important criminal cases relating to DME, infusion therapy, physical therapy, and other types of Medicare and Medicaid fraud.

Health Care Fraud Prevention and Enforcement Action Team

On May 20, 2009, Secretary of HHS Kathleen Sebelius and Attorney General Eric Holder announced the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT), an interagency effort focused specifically on combating health care fraud. HEAT includes senior officials from DOJ and HHS who are strengthening programs, as well as investing in new resources and technologies, to prevent and combat fraud, waste, and abuse. A key component of HEAT task force efforts is expansion of Medicare Fraud Strike Force operations. Strike Forces began in March 2007 and are operating in seven major cities—Miami, Florida; Los Angeles, California; Detroit, Michigan; Houston, Texas; Brooklyn, New York; Baton Rouge, Louisiana; and Tampa, Florida. The Strike Force teams coordinate law enforcement operations with other Federal, State, and local law enforcement entities. These teams have a proven record of success analyzing real-time data to quickly identify and prosecute fraud almost as it occurs.

During this reporting period, Strike Force efforts have resulted in the filing of charges against 88 individuals or entities, 89 convictions, and \$71.3 million in investigative receivables.

Examples of Strike Force efforts during this reporting period follow:

- **Michigan** – Dr. Jose Castro-Ramirez (Dr. Castro) was sentenced to 14 years in prison and ordered to pay \$9,769,113 in joint and several restitution after being convicted of health care fraud, conspiracy to commit health care fraud, and money laundering. Suresh Chand, the owner and operator of two rehabilitation companies, was sentenced to 6 years and 9 months' incarceration and ordered to pay \$9,769,113 in joint and several restitution after pleading guilty to conspiracy to commit health care fraud and conspiracy to launder money. Between January 2003 and March 2007, Chand and his co-conspirators submitted claims to Medicare for physical and occupational therapy services and other medical services that were never provided. Chand paid licensed physical and occupational therapists to sign fictitious "progress notes" and other documents that appeared to reflect that physical and occupational therapy services had been provided to the beneficiaries, when in fact they had not.

Dr. Castro signed medical records then billed Medicare for physical therapy, occupational therapy, and other services that were either not medically necessary or not rendered.

Evidence at trial proved that Dr. Castro had not overseen any treatment provided to the patients and, in many instances, he never saw the beneficiaries. Evidence presented at trial also showed that Chand provided Dr. Castro with lists of the controlled substances or drugs the beneficiaries preferred, and Dr. Castro wrote thousands of prescriptions for the substances without seeing the patients. Proceeds of the fraud were laundered and distributed through shell corporations owned by Chand and his co-conspirators. Previously, co-defendants Solomon Nathaniel, Syed Aziz, Sandeep Aggarwal, Baskaran Thangarasan, Jay Jha, and Jaquita Lovelace were sentenced to prison terms ranging from 1 day to 5 years and 2 months for their involvement in the scheme.

- **Michigan** – Fifteen defendants, including Medicare beneficiaries, physicians, and infusion therapy clinic owners and employees, were convicted on charges related to their participation in health care fraud schemes at clinics throughout the Detroit metropolitan area. During this reporting period, defendants John Saunders, Wayne Smith, Dr. Toe Myint, Terrence Hicks, Samuel Mott, Jose Martinez, Denisse Martinez, Larry Dickerson, William Reeves, Muhammad Al-Mahdi, and Lill Vargas-Arias were all convicted on charges related to health care fraud and were sentenced to prison terms ranging from time served to 6 years and ordered to pay more than \$3.7 million in joint and several restitution. According to court documents, businesses Xpress Center, Sacred Hope Center, Dearborn Medical & Rehab Center, and RDM Centers employed similar schemes to defraud Medicare, including (1) recruiting and paying beneficiaries to receive services at the clinics that were either not medically necessary or were not provided, (2) providing beneficiaries with prescriptions for medications that the defendants decided were more likely to generate Medicare reimbursements rather than for reasons based on medical need, and (3) submitting false and fraudulent claims to Medicare for these purported services. Co-defendants Victor Dozier, Louis Jackson, and Daisey Martinez were previously sentenced to prison terms ranging from time served to 8 years for their involvement in these schemes.
- **California** – Ajibola Sadiqr, owner and operator of Cooper Medical Supply, pleaded guilty to conspiracy to commit health care fraud and was sentenced to 4 years and 7 months in prison and ordered to pay \$508,134 in restitution. Between January 2006 and September 2009, Sadiqr conspired with Leonard Nwafor, the owner of another DME supply company; patient recruiter Maria Moreno; and others to fraudulently obtain beneficiary information and create illegitimate prescriptions and medical documents to sell to DME companies. Witnesses testified at trial that Moreno purported to be a representative of Medicare or another Government agency and went door-to-door at senior communities to obtain beneficiary information. Sadiqr and his co-conspirators billed Medicare for unnecessary high-end power wheelchairs and other DME using fraudulent prescriptions and medical documents obtained by Moreno or purchased from other sources. Previously, Nwafor was sentenced to 9 years in prison and ordered to pay \$526,243 in restitution and Moreno was sentenced to 1 year and 1 day in prison and ordered to pay \$100,588 in restitution for their respective roles in the scheme.

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- **Florida** – Lissette Borges was sentenced to 3 years and 10 months’ incarceration and ordered to pay \$15,976,849 in joint and several restitution after pleading guilty to conspiracy to commit health care fraud. Borges owned L&A Billing, a billing company that submitted fraudulent claims to Medicare on behalf of several DME companies. Investigators learned that the DME companies provided Borges with a list of physicians and Medicare beneficiaries, and she randomly paired the physicians and beneficiaries together and billed Medicare for medical supplies that were never needed or used. In return for the billing, the DME companies paid Borges a percentage of the amount reimbursed by Medicare.
 - **Texas** – Helen Etinfoh and Paula Whitfield were convicted of health care fraud and conspiracy to commit health care fraud. Whitfield was sentenced to 21 months in prison and ordered to pay \$807,781 in joint and several restitution; Etinfoh is awaiting sentencing. According to evidence presented at trial, Etinfoh paid Whitfield kickbacks to recruit Medicare beneficiaries for her DME company, Luant & Odera. Whitfield visited the homes of beneficiaries and offered them power wheelchairs in exchange for their Medicare information, even though all of them could walk. Etinfoh then used a special hurricane code to bypass the need for a doctor’s order and billed Medicare for DME such as wheelchairs, wheelchair accessories, and motorized scooters that were medically unnecessary for the recruited beneficiaries.

Pharmaceutical Companies

- **Pennsylvania** – AstraZeneca, LP, and AstraZeneca Pharmaceuticals, LP, (collectively, AstraZeneca) agreed to pay \$520 million plus interest and enter into a 5-year CIA to resolve their civil FCA liability in connection with the promotion of the drug Seroquel. Seroquel is an atypical antipsychotic drug approved by the Food and Drug Administration (FDA) for the treatment of schizophrenia and acute manic episodes associated with bipolar disorder. Between January 2001 and December 2006, AstraZeneca is alleged to have promoted Seroquel for uses that were not approved by the FDA as safe and effective, including aggression, anxiety, dementia, depression, and Alzheimer’s disease. AstraZeneca also allegedly violated the Federal anti-kickback statute by offering and paying illegal remuneration to doctors in connection with services rendered by the doctors relating to the unapproved uses of Seroquel.
- **Maryland** – Alparma Inc., and its subsidiary, Alparma Pharmaceuticals, LLC (collectively, Alparma), agreed to pay \$42.5 million plus interest to resolve FCA allegations that it provided illegal kickbacks to increase the marketing of Kadian, its morphine-based drug. Between January 2000 and December 2008, Alparma was alleged to have paid health care providers to induce them to promote or prescribe Kadian and made misrepresentations about the safety and efficacy of the drug. Alparma was alleged to have recruited physicians in a position to prescribe Kadian and entered into sham consulting arrangements with them. Alparma also was alleged to have engaged in other kickback conduct, including: (1) paying above-market fees to referral sources to participate in research projects; (2) conducting an “Interactive Consulting Forum” for which hundreds of

physicians were paid to provide feedback on Kadian; and (3) sponsoring a “Speaker’s Bureau” on which an excessive number of physicians were paid to serve.

Hospitals

- **Ohio** – Parma Community Hospital (Parma), Norton Healthcare (Norton), and St. Jude Medical, Inc., (St. Jude), agreed to pay the Government \$40,000, \$133,300, and \$3,725,000, respectively, to resolve allegations of illegal kickbacks resulting in false claims submitted to Medicare. St. Jude, a heart device manufacturer, was alleged to have offered and paid kickbacks to Norton and Parma, which agreed to buy certain percentages of St. Jude manufactured implantable cardioverter-defibrillators (ICD) and pacemakers. The kickbacks allegedly took the form of account credits towards the hospitals’ future purchases of other St. Jude devices.
- **Ohio** – The Health Alliance of Greater Cincinnati (THA) and University Internal Medicine Associates, Inc. (UIMA), agreed to pay \$2.5 million and \$100,000, respectively, to resolve their liability under the FCA in connection with an illegal kickback scheme. THA was a conglomerate of hospitals, which included Fort Hamilton Hospital (FHH) and The University Hospital (TUH) that operated under a joint operating agreement. THA was alleged to have used a clinical trial intended to investigate outcomes of two elective coronary intervention procedures as a smokescreen for an illegal referral relationship with UIMA that extended beyond participation in the trial. Specifically, UIMA allegedly agreed to provide FHH with patient referrals in exchange for FHH sending all unassigned cardiology patients and patients needing interventional procedures to UIMA cardiologists. The UIMA cardiologist would then allegedly perform the procedures at either FHH or TUH, generating revenue for the THA hospitals. THA officially disbanded in April 2010.

Durable Medical Equipment Suppliers

- **Florida** – Yasmany Benavides was sentenced to 12 years’ imprisonment and ordered to pay \$6,206,697 in joint and several restitution following his conviction for health care fraud and conspiracy to commit health care fraud. From about December 2003 through August 2004, Benavides submitted claims to Medicare on behalf of Lily Orthopedic, Inc., for DME and services that physicians did not prescribe or were not supplied as claimed. Previously, Erich Ruiz was sentenced to 2 years and 6 months’ imprisonment for his involvement in the submission of false claims on behalf of Lily Orthopedic, Inc. Ruiz is also responsible for paying \$4,484,797, a portion of Benavides’ restitution amount.
- **North Carolina** – Kalu Kalu, owner of Enuda Healthsource, a DME company, was sentenced to 7 years and 6 months’ incarceration and ordered to pay \$4,611,988 in joint and several restitution after pleading guilty to charges related to a scheme to defraud the Medicare program. From about December 2004 through July 2008, Kalu, along with Martin Iroegbu, the owner of another DME company, submitted claims for more expensive DME than was delivered to beneficiaries and for DME that was medically unnecessary or not delivered at all. Employees from both DME companies falsely represented during

presentations at Medicare beneficiaries' homes and churches that they could receive free medical equipment from the government. After the employees obtained beneficiaries' Medicare numbers, physicians' names, and their medical conditions, they completed fraudulent prescription forms for submission to Medicare. Iroegbu was previously sentenced to 2 years and 2 months' incarceration and ordered to pay \$575,430 in restitution for health care fraud.

Practitioners

- **Virginia** – Hematologist and oncologist Dr. Ronald Poulin was convicted following a jury trial, sentenced to 5 years and 3 months' incarceration, and ordered to pay \$790,641 in restitution for health care fraud, false statements relating to health care matters, and alteration of records to obstruct an investigation. Dr. Poulin defrauded Medicare and TRICARE by billing for more chemotherapy drugs than patients received and for submitting claims for office visits at a higher reimbursement level than what was rendered. He also directed his staff to alter and falsify patient record entries to support the false claims.
- **New York** – Podiatrists Ira Bell and Douglas Herzlich were the final two defendants sentenced out of 16 involved in a large-scale health care fraud scheme at Citywide podiatry clinics, which are in New York City. Bell and Herzlich, both of whom pleaded guilty in 2002, were ordered to pay restitution of \$275,139 and \$72,529, respectively, and Herzlich was sentenced to time served. The scheme, which dated to the 1980s, included soliciting patients for "free" treatments, billing for services not rendered, billing for medically unnecessary services, and/or billing for upcoded services in order to receive a higher reimbursement. The 16 defendants, including billing and administrative staff of Citywide, were convicted and ordered to pay over \$1.8 million in total restitution.
- **Pennsylvania** – Pursuant to his guilty plea, Dr. John Kristofic was sentenced to 12 months and 1 day in prison for health care fraud. Previously, Kristofic agreed to pay \$3,303,187 to resolve his liability under the FCA. The civil settlement resolved allegations that from January 2003 to August 2008, Dr. Kristofic submitted claims to Medicare, TRICARE, and the Federal Employees Health Benefits Program for services not rendered to his patients either because Dr. Kristofic was not in the office or the patients were in hospitals under the care of other physicians on the dates claimed. Dr. Kristofic also regularly billed for treatments that his patients never received.

Transportation Companies

- **Indiana** – Randy Suddoth was sentenced to 2 years' incarceration and ordered to pay \$1,201,163 in restitution after pleading guilty to conspiracy to commit health care fraud. Suddoth owned Lane Medical Transportation (Lane Medical), a sham company that did not own or use any ambulances, but submitted false claims for non-existent ambulance trips and basic life support. Investigators interviewed beneficiaries whom Lane Medical claimed to have transported, but the beneficiaries had never heard of the company.

Prescription Drugs

- **Pennsylvania** – Pharmacist Craig Goldman was sentenced to 18 months in prison and ordered to pay \$576,000 in restitution after pleading guilty to charges of drug adulteration and misbranding, health care fraud, mail fraud, and aiding and abetting. Goldman, who owned and operated Bergman Pharmacy as a compounding pharmacy, replaced proprietary drugs with compounded versions without physician direction. Goldman then billed Medicare and private insurers as if the proprietary drugs were dispensed. The investigation also revealed that Goldman’s compounded drugs were contaminated with bacteria, and that he manufactured the compounded drugs without using medicinal quality water, wearing gloves, or wearing a mask. Additionally, in making a budesonide-based drug intended for asthma patients, Goldman used chemicals such as ethyl alcohol and Everclear (a pure grain alcohol), which are severe irritants to the respiratory system.
- **North Carolina** – Kathleen Giacobbe and Dr. Porfirio Orta-Rosario were found guilty in an unlawful prescription drug operation whereby they distributed powerful, addictive painkillers and anti-anxiety medications to thousands of customers nationwide. Giacobbe was sentenced to 6 years and 3 months in prison and Dr. Orta-Rosario was sentenced to 5 years in prison for conspiracy to distribute schedule III and schedule IV controlled substances, distribution of a schedule III controlled substance, and aiding and abetting the unlawful distribution of controlled substances. According to evidence presented at trial, Giacobbe and Dr. Orta-Rosario conspired with others to distribute prescription painkillers and anti-anxiety medications based on illegitimate prescriptions from Giacobbe’s online pharmacy. Individuals with no training or authority to write prescriptions conducted telephone interviews with customers, and then created drug orders bearing a doctor’s photocopied signature. The defendants faxed the drug orders to Woody Pharmacy because Giacobbe knew Woody Pharmacy would not question the legitimacy of the prescriptions. Trial testimony and evidence established that this operation resulted in the distribution of millions of dosage units of controlled substances from Woody Pharmacy, and the court found that this unlawful operation contributed to the deaths of three former customers. Previously, the owner of Woody Pharmacy, Dr. Alvin Woody, was sentenced to 3 years and 4 months in prison for charges related to this scheme.

Quality of Care

- **Pennsylvania** – Nine employees at MultiEthnic Behavioral Health Services, Inc., (MEBH) were sentenced for charges related to health care fraud and the death of an at-risk child who was under MEBH’s care. MEBH co-founders Mickal Kamuvaka and Mariam Coulibaly, supervisor Solomon Manamela, and employee Julius Murray were convicted of health care fraud, wire fraud, and conspiracy to obstruct a matter within the jurisdiction of a Federal agency. Coulibaly was also convicted of making false statements. Five other MEBH employees previously pleaded guilty to charges in connection with the fraud scheme. The nine defendants were sentenced to prison terms ranging from 15 months to 17 years and

6 months and were ordered to pay joint and several restitution ranging from \$316,000 to \$1,216,000.

MEBH, a contractor for the Philadelphia Department of Health Services, came under Federal and local investigation in 2006 after the death of a 14-year-old special-needs child with cerebral palsy who was supposed to be receiving services from MEBH. Murray was responsible for ensuring that the 14-year-old and other at-risk children received medical treatment, services for their disabilities, and schooling. Instead, the child was severely neglected to the point that she suffered severe bed sores and slowly starved, until she weighed only 42 pounds and died. After her death, Kamuvaka orchestrated a massive coverup, including the destruction of old records and the fabrication of new false records. The defendants' fraudulent activity also included creating false documentation for other patient visits that did not occur, forging guardian signatures, destroying records, fabricating documents, and other egregious activities intended to satisfy yearly audit requirements to maintain their contract with the State.

Other Criminal Enforcement

- **Louisiana** – Nikkie LaFleur was sentenced to 3 years and 1 month in prison and ordered to pay \$621,737 in restitution after pleading guilty to charges of health care fraud and criminal forfeiture. LaFleur was an account manager at Medical Provider Services, a billing service for physicians and other medical providers in Louisiana. According to court documents, LaFleur forged doctors' endorsements then billed Medicare and private insurance companies for services not rendered and upcoded diagnoses for higher reimbursement. LaFleur deposited both Medicare and private insurance companies' checks into her personal checking account and used the money to purchase items such as two jet skis, a tandem trailer, a 22-foot motorboat, a boat trailer, and a 13-foot travel trailer.

Medicaid Fraud

- **Idaho** – Vanessa Cattanea was sentenced to 20 months' incarceration and ordered to pay \$1,054,259 in restitution after she was found guilty of aiding and abetting health care fraud. Cattanea was the treatment director for Teton Family Services, a company owned by Ronald Hamilton that provided mental health services to children. Between August 2002 and March 2006, Hamilton and Cattanea knowingly and fraudulently billed Medicaid for services performed by unlicensed staff and for trips to Yellowstone National Park, Bear Lake, and Salt Lake City, which were not reimbursable Medicaid services. Hamilton, who was also found guilty of health care fraud, died in March 2010.

Medicaid Fraud Control Units

MFCUs are key partners in the fight against fraud, waste, and abuse in State Medicaid programs. In FY 2009, HHS awarded \$189.9 million in Federal grant funds to 50 State MFCUs (including Washington, DC), which employed a total of 1,835 individuals.

Collectively, in FY 2009, MFCUs reported 26,744 investigations, of which 17,090 were related to Medicaid fraud and 9,654 were related to patient abuse and neglect, including patient funds cases. The cases resulted in 1,539 individuals being indicted or criminally charged, including 960 for fraud and 579 for patient abuse and neglect, including patient funds cases. In total, 1,331 convictions were reported in FY 2009, of which 19 were related to Medicaid fraud and 512 were related to patient abuse and neglect, including patient funds cases.

Joint Investigations

- **Pennsylvania** – Pediatrician Dr. Saroj Parida was sentenced to 8 years' incarceration and ordered to pay \$7,116,423 in restitution after pleading guilty to charges of health care fraud, mail fraud, and forfeiture. From 2003 through 2009, Dr. Parida submitted fraudulent claims to Medicaid, TRICARE, and private insurance companies for services not rendered. The investigation involved OIG, the U.S. Postal Inspection Service, the Defense Criminal Investigative Service, the Pennsylvania Attorney General's MFCU and Insurance Fraud Section, the South Carolina Attorney General's MFCU and Insurance Fraud Division, and the Cumberland County, Pennsylvania, District Attorney's Office.
- **South Dakota** – Reed Hittle, physical therapist and owner of Precision Physical Therapy, Inc., was sentenced to 10 months' home confinement and ordered to pay \$119,260 in restitution for his guilty plea to charges of false statements relating to health care matters. Between January 2005 and July 2008, Hittle billed Medicare and Medicaid for physical therapy treatments on patients, documenting that he performed the treatments himself. However, many of the billed treatments were administered by an unlicensed and untrained assistant. The investigation involved OIG, the FBI, and the South Dakota MFCU.