

# Part III

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## Part III

# Legal and Investigative Activities Related to Medicare and Medicaid

## Investigative Outcomes

For FY 2011, we reported 614 criminal and 381 civil actions against individuals or entities that engaged in health-care-related offenses. We also reported \$3.6 billion in Department of Health and Human Services (HHS) investigative receivables and \$947 million in non-HHS investigative receivables (such as from our work related to the States' share of Medicaid restitution). Such receivables, which represent expected recoveries, result from civil and administrative settlements or civil judgments related to Medicare, Medicaid, and other Federal, State, and private health care programs. Health-care-related investigative outcomes generally reflect the successful collaboration of our office and other enforcement entities.

## Advisory Opinions and Other Guidance

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.

Pursuant to 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. During this period, we received 44 requests for advisory opinions. We issued 12 new opinions and 2 modifications of earlier opinions.

The Web link to our advisory opinions is at <http://oig.hhs.gov/compliance/>. Other information that can be accessed at the same link includes voluntary compliance program guidance directed at various segments of the health care industry, open letters to health care providers from the Inspector General alerting them to OIG policies and processes, special fraud alerts and bulletins, the process providers should follow when voluntarily self-disclosing potential fraud, and corporate integrity agreements (CIA) with health care providers and other entities. Recent activity concerning self-disclosure, CIAs, and other administrative sanctions are discussed in this section of the Semiannual Report.

## HEAT: Health Care Fraud Prevention and Enforcement Action Team

On May 20, 2009, HHS Secretary 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.

## Strike Force Activities

The Medicare Fraud Strike Force is a key component of HEAT. The Strike Force began in March 2007 and is operating in nine cities—Miami, Florida; Los Angeles, California; Detroit, Michigan; Houston, Texas; Brooklyn, New York; Baton Rouge, Louisiana; Tampa, Florida; Chicago, Illinois; and Dallas, Texas. Strike Force teams coordinate law enforcement operations among Federal, State, and local law enforcement entities. These teams have a proven record of success in analyzing data to quickly identify and prosecute fraud. During this reporting period, Strike Force efforts have resulted in the filing of charges against 70 individuals or entities, 77 convictions, and \$160.8 million in investigative receivables.

In late August and early September 2011, Medicare Fraud Strike Force teams in 8 cities executed a nationwide operation that resulted in charges against 91 defendants, including doctors, nurses, and other medical professionals, for their alleged participation in Medicare fraud schemes involving approximately \$295 million in false billing. This coordinated operation involved the highest amount of false Medicare billings in a single takedown in Strike Force history. In addition to making arrests, agents executed 18 search warrants in connection with ongoing Strike Force investigations.

The defendants charged are accused of various health care fraud-related crimes, including conspiracy to defraud the Medicare program, health care fraud, violations of the anti-kickback statutes, and money laundering. The charges are based on a variety of alleged fraud schemes involving various medical treatments and services, such as home health care, physical and occupational therapy, mental health services, psychotherapy, and durable medical equipment. In conjunction with this major Strike Force operation, OIG collaborated with CMS to impose payment suspensions that immediately prevented a loss of more than \$552,000 in claims submitted by Strike Force targets.

Additional examples of Strike Force efforts during this reporting period are highlighted below.

- FLORIDA – Lawrence Duran**, one of several owners of **American Therapeutic Corporation (ATC)**, was sentenced to 50 years' incarceration for his role in orchestrating a Medicare fraud scheme. This case is the first Community Mental Health Center investigation under the HEAT initiative to lead to an indictment, and Duran's 50-year prison sentence is the longest imposed in a Medicare Fraud Strike Force case. **Marianella Valera**, another ATC owner, and **Margarita Acevedo**, a senior-level ATC manager, were also sentenced to 35 and 7.5 years' incarceration, respectively, for their roles in the scheme. In addition, Duran, Valera, and Acevedo, along with ATC and **Medlink Professional Management Group Inc.** (Medlink), which is also owned and operated by Duran and Valera, were ordered to pay more than \$87 million in restitution, jointly and severally. The now defunct ATC was a Florida corporation that purportedly provided intensive treatment programs for individuals with severe mental illness. Between 2002 and 2010, Duran and Valera used ATC to bill Medicare for mental health services that were not necessary or were never provided. The pair actively recruited and paid kickbacks to owners and operators of assisted living facilities, halfway houses, and patient brokers in exchange for delivering ineligible patients to ATC. Additionally, Duran and Valera caused the alteration of patient files and therapist notes to appear as if the ATC patients qualified for intensive treatment programs.
- MICHIGAN –** One of OIG's 10 most wanted fugitives, **Reynel Betancourt**, was sentenced to 77 months' incarceration and ordered to pay over \$6 million, jointly and severally, in restitution for his role in a health care fraud and money laundering scheme. Betancourt was an employee at the **Dearborn Medical and Rehabilitation Center (DMRC)** which purportedly specialized in infusion and injection therapy for human immunodeficiency virus (HIV)-positive patients. Betancourt recruited and paid Medicare beneficiaries to act as DMRC patients, and the patients, in return, signed medical documentation and reimbursement forms that DMRC could use to bill Medicare for services never rendered. Additionally, Betancourt owned a company called

**Perfect Data Request**, which he used to launder over \$400,000 in Medicare payments. Betancourt fled the United States to avoid being apprehended. Betancourt was arrested in the Dominican Republic on November 29, 2010, and transferred into custody of U.S. officials.

- **FLORIDA – Dr. Rene De Los Rios** was sentenced to 235 months' incarceration and ordered to pay a minimum of \$11.7 million in restitution, jointly and severally, with his co-defendants for conspiracy to commit health care fraud and submission of false claims. De Los Rios was employed by **Metro MED of Hialeah Corporation** (Metro Med), a clinic that provided injection and infusion therapies to HIV-positive Medicare beneficiaries. Between April 2003 and October 2005, De Los Rios signed medical analysis and diagnosis forms and authorized treatments that were medically unnecessary or were never provided. The owner and operator of Metro Med, **Damaris Oliva**, and three other co-defendants, **Estrella Rodriguez**, **Jose Diaz**, and **Lisandra Aguilera**, were each sentenced to 82 months, 57 months, 54 months, and 70 months of incarceration, respectively, for their roles in the scheme.
- **MICHIGAN – Maria Haber**, co-owner of **CompleteHealth, LLC**, and **Ritecare, LLC**, was sentenced to 15 months' incarceration and ordered to pay \$1 million in restitution, jointly and severally, with her co-defendants for her role in a Medicare fraud scheme. CompleteHealth and Ritecare were nerve conduction clinics in Livonia, Michigan. Between September 2007 and June 2008, Haber and co-conspirators used the clinics to bill Medicare for unnecessary tests and services, including nerve conduction studies. Patient recruiters were paid \$100 to \$150 for every patient that was brought into the clinic, and the patients received \$50 to \$75 in exchange for subjecting themselves to the medically unnecessary tests.

### Provider Compliance Training Sessions

OIG's HEAT Provider Compliance Training initiative (HEAT PCT) provided free high-quality compliance training for providers, compliance professionals, and attorneys in Strike Force cities and elsewhere. HEAT PCT, which included presenters from HHS/OIG, Centers for Medicare & Medicaid Services (CMS) Regional Offices, CMS Program Integrity, United States Attorneys' Offices, and State Medicaid Fraud Control Units, held sessions in Houston, Tampa, Kansas City, Baton Rouge, Denver, and Washington, D.C., training a total of 737 in-person attendees. The final HEAT PCT session in Washington, D.C., was Webcast live to 2,335 participants. OIG developed comprehensive training materials to accompany HEAT PCT, and those materials are now available online, together with [16 video modules](#) dividing the Webcast by subject area. The online training will continue reaching the health care community with our compliance message.

## Other Criminal and Civil Enforcement Activities

### Special United States Attorneys Program

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 D. The successful resolution of false claims investigations often involves the combined investigative efforts and resources of OIG and other Federal and State law enforcement agencies. During this reporting period, DOJ and OIG continued their Special United States Attorneys program in which OIG Special Agents who are also attorneys are detailed full-time to DOJ's Criminal Division, Fraud Section, for temporary assignments, such as assignments with the Medicare Fraud Strike Force described above; 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 their efforts to fight fraud. Under this program, OIG attorneys have successfully litigated important criminal cases relating to durable medical equipment (DME), infusion therapy, physical therapy, and other types of Medicare and Medicaid fraud.

### Most-Wanted Fugitives Listed on OIG's Web Site

Earlier this year, we published a Most-Wanted Fugitives list on our Web site. By the end of this reporting period, seven individuals had been captured. We continuously update the list and provide a means for the public to report tips regarding the whereabouts of the fugitives. Following is the link for accessing the Most-Wanted Fugitives list: <http://oig.hhs.gov/fraud/fugitives/>.

Notable enforcement actions and related activities are described below. Summaries are organized by the sector of the health care industry involved or by the nature of the offense.

### Prescription Drugs

- MARYLAND – Serono Laboratories, Inc.; EMD Serono, Inc.; Merck Serono S.A.; and Ares Trading S.A.** (collectively Serono), agreed to pay \$44.3 million plus interest and enter into an FCA settlement to resolve allegations that between January 2002 and December 2009, Serono paid illegal remuneration to health care professionals (for activities such as promotional speaking engagements, speakers' training, and charitable contributions) to induce them to prescribe their multiple sclerosis prescription drug called Rebif and, thereby, caused the submission of false claims to Medicare and other Federal health care programs. As part of a 2005 civil and criminal settlement relating to Serono's promotion of the drug Serostim, Serono entered into a corporate Integrity Agreement (CIA) with OIG. As part of the 2011 settlement, Serono entered into a 3-year addendum to the existing CIA.
- MISSOURI – Cardinal Healthcare, Inc. (CHI)**, agreed to pay \$8 million plus interest to resolve its liability under the civil FCA for allegedly submitting false claims to Medicare Part D and Medicaid. CHI allegedly paid a kickback to **Medicine Shoppe Pharmacies (Pharmacies)** to secure Pharmacies' pharmaceutical acquisition business. Pharmacies allegedly received a kickback in the form of an up-front cash payment, or "prebate," to switch their drug purchasing from a competitor to CHI, resulting in the submission of tainted, false claims for prescription drugs to the Medicare and Medicaid programs.
- MICHIGAN – eTEL-Rx, Inc. (eTEL-Rx)**, a pharmacy that provides drugs to nursing home facilities throughout the State, entered into a settlement agreement that includes restitution in the amount of \$650,000 to resolve its alleged liability under the civil FCA. Between January 1999 and December 2007, eTEL-Rx allegedly billed Medicaid directly for medications and nutritional supplements of terminally ill patients that should have been billed to the appropriate hospice providers. In addition, eTEL-Rx accepted the return of unused drugs paid for by Medicaid without crediting Medicaid for the returns. The pharmacy subsequently redispensed the returned drugs, resulting in Medicaid's paying eTEL-Rx again for the drugs already reimbursed by Medicaid. As part of the settlement, eTEL-Rx entered into a CIA with OIG.
- OHIO – James Matheny, Jr., and Jacob McCoy**, a Walgreens Pharmacy Technician and brother-in-law of Matheny, were sentenced to 27 months and 12 months and 1 day of incarceration, respectively, and ordered to pay \$6,131, jointly and severally, for their roles in a scheme to obtain controlled substances through using stolen identities and fraudulent prescriptions. Specifically, McCoy and Matheny obtained blank prescription pads in the name of **Columbus Pain Management**, a fictitious medical practice, and then wrote prescriptions for Class 2 controlled substances to include OxyContin and Percocet. McCoy also used his pharmacy's

computer system to obtain the identities of customers who possessed insurance benefits through Medicare, Medicaid, and Medicaid Managed Care Organizations (MCO). McCoy and Matheny then used this information to obtain the controlled substances at reduced prices. Matheny subsequently sold the prescription drugs on the street. Between March 2009 and June 2009, McCoy and Matheny diverted approximately 4,000 units of the prescription drugs.

## Hospitals

- **CONNECTICUT – Masonicare Health Center** (Masonicare) agreed to pay \$447,776 to resolve its liability for allegations under the FCA. The settlement agreement resolved allegations that Masonicare improperly overcharged the Medicare and Medicaid programs from January 1, 2001, through May 31, 2010, for Lupron injections, which are commonly used to treat prostate cancer in men and manage endometriosis in women. Using the Healthcare Common Procedure Coding System (HCPCS), Masonicare allegedly billed Medicare and Medicaid for Lupron injections provided to its male patients under an HCPCS code designated for female beneficiaries, which is reimbursed at double the rate. OIG reserved its right to exclude the entity.
- **OKLAHOMA – AHS Hillcrest Medical Center, LLC; AHS Tulsa Regional Medical Center, LLC; Ardent Health Services, LLC; and Ardent Medical Services, Inc.** (collectively the Ardent Entities) entered into an FCA settlement agreement and agreed to pay \$3.85 million to resolve allegations that between January 2003 and December 2009, the Ardent Entities caused false claims to be submitted to Oklahoma Medicaid. Specifically, the Children and Adolescent Behavioral Health Services Unit of the Tulsa Regional Medical Center (renamed Oklahoma State University Medical Center in 2006) allegedly failed to provide inpatient psychiatric services to patients under the age of 21 in the intervals of time required by State regulations. Instead, shorter therapy sessions were allegedly provided and documented as if they had been appropriately provided. In connection with this settlement, AHS Hillcrest Medical Center, which assumed ownership and operation of the Unit in 2009, entered into a 5-year CIA. The CIA obligations include oversight by a board of directors and an Independent Review Organization's (IRO) review of the Unit's claims and quality control systems.

## Durable Medical Equipment

- **WISCONSIN – Rikco International LLC, d/b/a Dr. Comfort** (Dr. Comfort), agreed to pay \$27 million plus interest and enter into a 5-year CIA to resolve its liability under the FCA in connection with the alleged sale of DME that was reimbursed by Medicare. Between June 2004 and March 2006, Dr. Comfort allegedly shipped diabetic orthotic shoe inserts to DME suppliers under the false pretense that the inserts were approved by Medicare for reimbursement and that the inserts met specifications established by the Centers for Medicare & Medicaid Services (CMS) when, in fact, they did not meet the specifications.
- **FLORIDA – Omar Perdomo**, owner and operator of **Eagles Pharmacy Corp.** (Eagles Pharmacy), was sentenced to 52 months' incarceration and ordered to pay \$3.9 million in restitution for health care fraud. Between August 2006 and April 2007, Perdomo used Eagles Pharmacy to submit false and fraudulent claims to Medicare, including claims for deceased beneficiaries. These claims sought reimbursement for the cost of DME, prescription medications, and other items and services for Medicare beneficiaries in Florida that were not prescribed by doctors or provided as claimed.
- **TENNESSEE – Ignace Tchamgoue**, owner of **Tigen Healthcare Solutions, Inc.** (Tigen), was sentenced to 18 months' incarceration and ordered to pay \$156,052 in restitution for health care fraud and aiding and abetting. Tigen was a DME supplier in Memphis, Tennessee. Between February and

December 2009, Tchamgoue electronically submitted false claims to Medicare for medically unnecessary enteral (tube feeding) products and supplies.

- **FLORIDA – Carlos Gomez** was sentenced to 55 months' incarceration and ordered to pay \$1.66 million in restitution, portions of which are joint and several with co-defendants, for defrauding the Medicare program. From October 18, 2005, through June 1, 2007, Gomez owned and operated **Carpio Medical Equipment Services, Inc.** (Carpio Medical), a DME supply company. Between July 2006 and January 2007, Gomez caused Carpio Medical to submit false and fraudulent Medicare claims for DME items, such as pressure support ventilators, therapy pumps, and other DME that were not prescribed by physicians or received by Medicare beneficiaries.

## Practitioners

- **NEVADA – Rakesh Nathu, M.D., and Nathu Compassionate Cancer Care, Chartered** (collectively Nathu), agreed to pay \$5.7 million plus interest to settle allegations under the FCA for the false billing of radiation oncology services, including intensity modulated radiation therapy. Intensity modulated radiation therapy is a treatment for specific types of cancer in which extreme precision is required to spare surrounding organs or healthy tissue. Between 2007 and 2009, Nathu allegedly submitted improper claims to Medicare, TRICARE, and the Federal Employees Health Benefits Plan by double-billing for procedures related to radiation treatment plans. Nathu also allegedly billed for services that were medically unnecessary and billed higher reimbursement radiation services when a different, less expensive service should have been billed. This was a joint investigation with the Federal Bureau of Investigation.
- **PENNSYLVANIA – Ronald Bailey, EdD**, a behavioral specialist consultant, was sentenced to 18 months of incarceration and ordered to pay \$164,640 in restitution for health care fraud. Bailey was employed by the Chester County Regional Educational Services, Inc. (CCRES), which contracted with the Chester County Intermediate Unit (CCIU). During that same time, Bailey was also employed with an organization called Devereux. While providing behavioral services to Devereux and CCIU, Bailey routinely prepared and submitted invoices that overstated the amount of time he spent with clients. Bailey's scheme included forging signatures of parents of Medicaid beneficiaries on encounter forms to appear as though he had spent the number of hours with the clients as listed on the forms. Bailey also prepared and submitted separate invoices to both Devereux and CCIU which, on many occasions, reflected that he was at two different locations at the exact same time seeing different Medicaid beneficiaries. Relying on the fraudulent invoices submitted by Bailey, CCIU, through CCRES, and Devereux issued check payments to Bailey for the claimed services with funds issued by the State Medicaid program. This was a joint investigation with the Pennsylvania Medicaid Fraud Control Unit.

## Clinics

- **NORTH CAROLINA – Dr. Michael Nunn, d/b/a Community Wellness Center**, was ordered to pay restitution in the amount of \$297,215 and his practice was ordered to pay a fine of \$700,000 for health care fraud and money laundering. The court order also barred Nunn from engaging in business with HHS, the Department of Veterans Affairs (VA), and any other agency impacted by his offense. Between May 2003 and December 2004, Nunn operated three clinics in New Bern, Winterville, and Morehead City, North Carolina. Medicare, Medicaid, and VA patients frequently visited his clinics to obtain prescriptions for controlled substances. As a condition for receiving the prescriptions, Nunn required the patients to undergo various forms of physical and psychological therapy that were performed by unlicensed and unqualified personnel or provided by qualified practitioners without proper supervision. The therapy was subsequently billed to Medicare, Medicaid, and VA.

- VERMONT – **Dartmouth Hitchcock Clinic, Mary Hitchcock Memorial Hospital**, and related entities (collectively Dartmouth), agreed to pay \$2.2 million to resolve its liability under the FCA for allegedly submitting improper claims to Medicare, Medicaid, TRICARE, and VA. Between February 1, 2001, and September 30, 2007, Dartmouth’s Anesthesiology Department (AD) allegedly: submitted improper claims for services not supervised by attending physicians in the AD’s Pain Clinic, submitted improper claims for services not supervised by attending physicians related to bedside procedures, and submitted improper claims for time-based billings in the AD’s Critical Care Unit. According to Federal regulations and related guidelines, physicians are allowed to bill for certain services provided by residents, but only if those services are performed while a physician is present and the medical record documents physician presence. In addition, Dartmouth allegedly submitted improper supervision and interpretation claims for services provided by its Radiology Department. These claims were improper because they did not have sufficient medical record documentation to support the supervision component of these claims.
- CALIFORNIA – **Susan Nahapetian** was ordered to pay restitution in the amount of \$994,109, jointly and severally, with her co-conspirator, **Rudik Avakyan**, for her participation in a widespread health care fraud scheme. Avakyan orchestrated the recruitment of physicians in northern and southern California to establish medical clinics throughout the State. Nahapetian served as the office manager for one of the clinics in San Jose, California. These clinics paid individuals known as cappers to recruit patients and entice them to visit the clinics by offering inducements, such as gift certificates and cash payments. The clinics subsequently billed Medicare for office visits, physical therapy, and other procedures and diagnostic tests that were unnecessary, were not rendered, or were rendered by unlicensed staff. The clinics also billed Medicare for patients that were deceased. Avakyan was sentenced on February 28, 2011, to 39 months’ incarceration and restitution in the amount of \$2 million for his role in the conspiracy.

### Home Health Services

- NEW JERSEY – **Maxim Healthcare Services** (Maxim), agreed to pay \$121 million plus interest over 8 years and enter a Corporate Integrity Agreement to resolve its liability for allegations under the False Claims Act. In addition, Maxim paid \$20 million in criminal fines. The settlement resolves allegations that, between 1998 and 2009, Maxim, one of the country’s largest home health care agencies, filed false claims with state Medicaid programs and Veteran’s Affairs for services that were not provided, not sufficiently documented to show that they were provided, or were delivered from unlicensed offices.

### Skilled Nursing Facility

- WEST VIRGINIA – **Genesis Rehabilitation Services** (GRS), an affiliate of **Genesis HealthCare LLC**, agreed to pay \$1.5 million to resolve its liability under the FCA for allegedly submitting claims to Medicare and Medicaid for services provided by an unlicensed speech therapist. Between October 2006 and June 2010, GRS allegedly employed an unlicensed speech therapist who provided forged licenses and documentation to GRS to maintain her employment. GRS failed to verify the documentation. As a result, GRS routinely submitted claims to Medicare and Medicaid for services for licensed speech therapy services that were provided by an unlicensed therapist.

### Transportation Fraud

- NORTH CAROLINA – **Dr. Janet Johnson-Hunter** was sentenced to 28 months incarceration and ordered to pay restitution to Medicare and Medicaid in the amount of \$428,924 and \$46,165, respectively. Johnson-Hunter and her husband, also a physician, owned **Coastline Care, Inc. (CCI)**, an ambulance company based in Magnolia, North Carolina. Between January 2002 and August

2005, CCI, under Johnson-Hunter’s direction, routinely conducted unnecessary transportation of patients to and from dialysis centers by ambulance that should have been transported by other means. Johnson-Hunter further instructed emergency medical technicians to omit the true condition of these patients from the ambulance call reports when she knew their conditions would not meet the Medicare and Medicaid reimbursement requirements.

- **TEXAS – Claudette Read and Robert Earl Read**, owners of **Priority One EMS** (Priority One), were sentenced to 108 months’ incarceration and ordered to pay \$1.7 million in restitution, jointly and severally, for submitting false claims to Medicare and Medicaid. Priority One was an ambulance transport business. Between January 2004 and November 2007, the Reads submitted, and instructed others to submit, claims to Medicare and Medicaid to obtain reimbursements for transporting dialysis patients who did not meet the required criteria for ambulance transportation. The Reads instructed employees on what information to include in the “reason for transport” section of the emergency medical service run sheets to ensure that the transports qualified for reimbursement by Medicare and Medicaid. The Reads also submitted claims for ambulance transportation to and from dialysis that falsely represented that the patients were transported individually when, in fact, multiple patients had been transported simultaneously in one ambulance. This was a joint investigation with the Texas Medicaid Fraud Control Unit.
- **NEW YORK – American Medical Response, Inc. (AMR)**, agreed to pay \$2.7 million plus interest and enter into a 5-year CIA to resolve its liability under the FCA. This settlement resolves allegations that between January 1, 2001, and December 31, 2005, AMR’s three Brooklyn locations submitted upcoded claims for ambulance transportation services to Federal health care programs. Upcoding occurs when a provider bills for a level of service higher than medically necessary. This was a joint investigation with the VA OIG.
- **TEXAS – The city of Dallas** agreed to pay \$2.47 million and enter a 3-year CIA to resolve its liability under the FCA related to allegations that it and ambulance billing company **Southwest General Services of Dallas, LLC**, improperly billed and obtained reimbursements from Medicare and Texas Medicaid for upcoded ambulance transports. The transports were provided by Dallas emergency management services between January 2006 and May 2010. OIG alleged that Dallas submitted false claims to Federal programs that were improperly coded as advanced life support, when, in fact, no such services were rendered and the patient did not require an advanced life support transport.

### Quality of Care

- **ARIZONA – Arete Sleep, LLC; Arete Sleep Therapy, LLC; and Arete Holdings, LLC** (collectively Arete) agreed to pay \$650,000 in a settlement to resolve FCA allegations. Between November 2002 and December 2009, Arete allegedly made false claims to Medicare for diagnostic sleep tests performed by technicians in its Arizona and Texas facilities who lacked the licenses or certifications required by Medicare rules and regulations. The settlement also resolves allegations that Arete further submitted false claims for medical devices, such as continuous positive airway pressure devices, resulting from the uncertified technicians’ tests.

## Medicaid Fraud Control Units

Under a delegation from the Secretary, OIG oversees and distributes funding to State Medicaid Fraud Control Units (MFCUs), which have the responsibility to investigate and prosecute Medicaid provider fraud and patient abuse and neglect. As part of its oversight responsibility, OIG ensures that the MFCUs are operating effectively and operating in a manner consistent with legal requirements, including those in the Social Security Act, § 1903(q), and in Federal regulations at 42 CFR pt. 1007. In FY 2010, OIG awarded

\$193.6 million in Federal grant funds to 50 State MFCUs (including the District of Columbia), which employed a total of 1,827 individuals. MFCUs are key partners in the fight against fraud, waste, and abuse in State Medicaid programs. Collectively, in FY 2010, MFCUs reported 13,210 investigations, of which 9,710 were related to Medicaid fraud and 3,500 were related to patient abuse and neglect, including theft from personal funds accounts of nursing home patients. The cases resulted in 1,603 individuals' being indicted or criminally charged, including 1,048 for fraud and 555 for patient abuse and neglect. In total, 1,329 convictions were reported in FY 2010, of which 839 were related to Medicaid fraud and 490 were related to patient abuse and neglect. An [interactive map](#) of MFCU data by State is available on our Web site.

On March 17, 2011, OIG issued a Notice of Proposed Rulemaking, 76 Fed. Reg. 14637, that would amend a provision in HHS regulations that prohibits MFCUs from using Federal matching funds to identify fraud through screening and analysis of State Medicaid claims data, known as data mining. The provision, contained in 42 CFR § 1007.19, would be amended to permit Federal matching for data mining when MFCUs meet certain conditions. Comments on the proposal were due on May 16, 2011.

### Joint Investigations

- CONNECTICUT – Dr. Mark W. Izard** and his corporation, **Mark W. Izard, M.D., P.C.**, agreed to pay \$2.2 million to resolve Izard's liability under the FCA for allegedly submitting improper claims to Medicaid and Medicare. Between July 2004 and April 2009, Izard allegedly billed for services provided to patients at nursing homes when, in fact, the patients were in the hospital on the alleged dates of services. In addition, Izard and his professional corporation allegedly submitted claims for attending physician services provided to hospital inpatients when the medical records did not support CMS's physical presence requirements for such claims. Izard allegedly billed for services that, according to the medical notes in the patients' charts, were performed by advanced-practice registered nurses or Hartford Hospital medical residents. Allegedly, it was Izard's regular practice to countersign the medical notes and not include his own note reflecting services he allegedly performed as the attending physician. As part of the agreement, Izard and his professional corporation both agreed to be excluded from the Federal health care programs for 7 years. This was a joint investigation with the Federal Bureau of Investigation (FBI) and the MFCU of Connecticut.
- MASSACHUSETTS – Aloysius Nsonwu**, owner of **Egleston Square Pharmacy** (Egleston), was sentenced in U.S. District Court to 9 months' time served and ordered to pay \$101,520 in restitution to Medicare and \$46,278.24 to Medicaid. In Massachusetts State Court, Nsonwu was sentenced to 4 years and 1 day in State prison, to be followed by 5 years' probation. He was also ordered to pay \$555,502 in restitution to Medicaid. Nsonwu's scheme included paying customers to bring their Medicare Part D and Medicaid cards to the pharmacy so that he could submit claims to CMS in their names. Nsonwu billed for prescription and refills of HIV/AIDS medications without physically dispensing the medication to the individuals. Many of the individuals whose insurance cards were improperly billed for were not, in fact, HIV positive. Nsonwu further used the identity of a licensed practicing physician without his knowledge to forge prescriptions for the medications. Nsonwu additionally paid cash to Medicaid beneficiaries in exchange for legitimate prescriptions. This was a joint investigation with the Medicaid Fraud Division of the Massachusetts Attorney General's Office and the Massachusetts State Police.

## Provider Self-Disclosure Protocol

### Self-Disclosure Guidance for Health Care Providers

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.

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

### Self-Disclosure Cases

During this reporting period, self-disclosure cases resulted in \$8.4 million in HHS receivables. The following are examples:

- **NEW YORK – St. Catherine of Siena Medical Center** (St. Catherine) agreed to pay \$2.5 million to resolve its liability under the Civil Monetary Penalties Law (CMPL). St. Catherine disclosed two improper financial arrangements, which created potential liability under the Stark Law and the anti-kickback statute. St. Catherine contracted with a physician-owned professional services company and had an employment agreement with a referring physician, both of which provided remuneration that was not consistent with the fair market value of the services provided.
- **TEXAS – The University of North Texas Health Science Center** at Fort Worth (UNTHSC) agreed to pay \$859,500 to resolve its liability under the CMPL. Between October 1, 2005, and March 31, 2009, UNTHSC submitted claims for physicians' services provided to Federal health care beneficiaries using the provider identification numbers of 103 physicians who neither furnished the services nor personally supervised them.

## Office of Inspector General Administrative Sanctions

During this reporting period, OIG imposed 1,825 administrative sanctions for fraud or abuse or other activities that pose a risk to Federal health care programs and their beneficiaries (see Appendix D 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 civil monetary penalties (CMP) for submitting false or fraudulent claims to a Federal health care program or for violating the anti-kickback statute, the Stark Law, or the Emergency Medical Treatment and Labor Act of 1986 (EMTALA or patient dumping statute). During this semiannual reporting period, OIG excluded 1,779 individuals and entities

from Medicare, Medicaid, and other Federal health care programs. Examples of program exclusions follow.

### Program Exclusions

- KANSAS – Stephen Schneider**, an osteopath, and **Linda Schneider**, a licensed practical nurse, were excluded for a minimum of 95 years each for their convictions related to conspiracy to commit health care fraud resulting in death, aiding and abetting the unlawful distribution of controlled substances resulting in serious bodily injury and death, unlawful distribution of controlled substances resulting in serious bodily injury, health care fraud resulting in death, health care fraud, and money laundering. The Schneiders owned and operated Schneider Medical Clinic, LLC, which they used to distribute and dispense controlled substances illegally and defraud patients of money by operating it as, in essence, a prescription mill and a narcotics delivery system, commonly known as a pill mill. The Schneiders engaged in this scheme for a 6-year period, during which numerous patients were hospitalized and numerous patients died because of overdoses of prescribed drugs. Additionally, the Schneiders were previously ordered to pay restitution in the amount of \$5 million and sentenced to 360 and 396 months of incarceration, respectively.
- OREGON – Sean Cluver**, a certified nurse assistant, was excluded for a minimum of 35 years based on his convictions of sodomy, attempted rape, sexual abuse, and criminal mistreatment. Cluver sexually abused two patients that were incapable of giving consent because of a mental disability. Cluver was sentenced to 175 months of incarceration, and his certificate to practice as a nurse assistant was revoked by the Oregon State Board of Nursing.
- CALIFORNIA – Vardges Egiazarian**, business owner and operator of three health care clinics in Sacramento, Richmond, and Carmichael, California, was excluded for a minimum of 30 years based on his health care fraud conviction. Over a 2-year period, Egiazarian participated in a scheme to defraud Medicare by submitting claims for office visits and testing that were not needed or rendered. Egiazarian used individuals known as cappers to recruit patients to his clinics. The patients were paid for their time and for the use of their Medicare eligibility. In addition, some of the patients for whom billings were submitted were deceased on the date that they were allegedly receiving services. Egiazarian was sentenced to 78 months' incarceration and ordered to pay \$1.5 million in restitution.
- FLORIDA –** On July 12, 2011, an HHS Departmental Appeals Board Administrative Law Judge (ALJ) upheld OIG's exclusion of **Michael D. Dinkel** from participation in all Federal health care programs under section 1128(b)(7) of the Social Security Act for 8 years. The exclusion was based on Dinkel's submission of false claims to the Medicare and Medicaid programs for current procedural terminology code 36005, a procedural code that corresponds to injection for extremity venography. The procedure denoted by this code was never performed at Dinkel's radiology company, **Drew Medical**. Specifically, the ALJ found that Dinkel caused the submission of nearly 9,500 false claims to Medicare and Medicaid for reimbursement. DOJ previously entered into a civil FCA settlement with Dinkel; Drew Medical; and Central Florida Radiology, Inc.
- CALIFORNIA –** In 2008, **Dr. Kamron Hakhamimi** was convicted of sexual exploitation of a patient and battery of that same patient. On the basis of Hakhamimi's conviction, OIG excluded him for a minimum of 12 years under section 1128(a)(2) of the Social Security Act. The length of exclusion was increased beyond the mandatory minimum of 5 years because two aggravating factors were present: (1) the acts underlying Hakhamimi's conviction consisted of premeditated and nonconsensual sexual acts and (2) Hakhamimi was the subject of other adverse action by the Medical Board of California and the California Department of Health Care Services. Hakhamimi appealed his exclusion and the ALJ upheld it as reasonable, finding that Hakhamimi's conviction

involved abuse of a patient in connection with the delivery of a health care item or service. Hakhamimi appealed the ALJ's decision and on August 25, 2011, the Appellate Division of the Departmental Appeals Board (DAB) upheld the ALJ's decision. The DAB found that the evidence shows that Hakhamimi "took advantage of his professional position for personal gratification" and they agreed with the ALJ that this "renders [Hakhamimi] manifestly untrustworthy to provide care to program beneficiaries and recipients of program funds."

### Corporate Integrity Agreements

Many health care providers that enter agreements with the Federal Government to settle potential liabilities under the FCA also agree to adhere to a separate CIA with OIG. Under a CIA, a provider typically commits to establishing a program or taking other specified steps to ensure future compliance with Medicare and Medicaid rules. The compliance programs are designed, in part, to prevent a recurrence of the underlying fraudulent conduct. OIG monitors providers' compliance with these agreements.

During this reporting period, OIG imposed stipulated penalties totaling \$272,500 on two companies, **Church Street Health Management** (Church Street, formerly known as FORBA Holdings, LLC) and **The SCOOTER Store, Inc.**, because they did not comply with requirements of their CIAs with OIG. A penalty of \$230,000 was imposed on Church Street because it failed to implement training, develop and distribute policies and procedures, submit an Independent Review Organization (IRO) report, and provide notice of Government investigations. Church Street also made false certifications. A penalty of \$42,500 was imposed on The SCOOTER Store, Inc., because it did not submit a timely IRO report, as required under its CIA.

### 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 \$10 million in penalties and assessments.

- **FLORIDA – Daniel Herrington** paid \$124,141 to resolve his liability for allegations under the CMPL. Herrington allegedly submitted false claims for diabetic shoe inserts through his DME company, One Source Medical Services. Herrington allegedly billed Medicare for custom-molded diabetic shoe inserts but, in fact, provided prefabricated inserts to beneficiaries.
- **MASSACHUSETTS – Beth Israel Deaconess Medical Center** (Beth Israel) paid \$233,932 to resolve its liability under the CMPL for allegedly submitting improper claims to Medicare for Lupron drug injections. Specifically, Beth Israel allegedly submitted claims for Lupron injections under a code that reimbursed at approximately double the rate as the code under which the claims should have been submitted.
- **INDIANA – Internal Medicine Associates** (IMA) paid \$58,573 to resolve its liability under the CMPL for allegedly employing a registered nurse who was excluded from participation in Federal health care programs.

### Patient Dumping

Some of the CMP cases that OIG resolved between April 1, 2011, and September 30, 2011, were pursued under EMTALA, a statute designed to ensure patient access to appropriate emergency medical services. The following are examples of settlements under this statute.

- **TEXAS – Dallas County Hospital District, d/b/a Parkland Health and Hospital System** (Parkland), paid \$50,000 to resolve its CMP liability for failing to provide an appropriate medical screening examination and treatment for a patient who presented himself to Parkland’s emergency department with an emergency medical condition. The patient had severe abdominal pain and waited for approximately 15 hours to receive a physical examination. The physician providing the physical examination determined that the patient required an electrocardiogram (EKG), laboratory studies, and imaging. Parkland did not perform the EKG nor did it perform any intravenous access or monitoring. Approximately 18 hours after arriving at the emergency department, the patient died of a heart attack. OIG alleged the delay in evaluation, treatment, and performance of diagnostic examinations was inappropriate and violated EMTALA.
- **CALIFORNIA – Santa Clara Valley Medical Center (SCVMC)**, an acute care facility in San Jose, agreed to pay \$48,000 to resolve its liability for violating EMTALA. On April 6, 2009, a 62-year-old male presented to SCVMC’s emergency department after receiving a referral from a nearby urgent care facility that diagnosed him with severely abnormal hemoglobin results that were suspected to be the result of serious internal bleeding. The patient provided medical documents from the urgent care facility to an SCVMC triage nurse illustrating severely low hemoglobin results and complained to the nurse of dizziness, blurred vision, and fatigue. The triage nurse stated that the patient did not appear to be in distress because he could walk. The nurse also stated that the referral documents from the urgent care facility were difficult to read. As a result, the patient was triaged as nonemergent. The patient waited in the waiting room for 7 hours while his heart rate steadily increased. There is no record that SCVMC notified a physician of the patient’s heart rate. The patient ultimately died in the waiting room without receiving a medical screening examination or stabilizing medical treatment.