

Second Quarter 2021

The information provided in *The Compass* is purely for informational purposes and each company should analyze and verify their own data and facts before initiating an investigation or taking other action.

- **Member Organization Intelligence**
- **Spotlight Articles**
- **Government Liaison Update**
- **SIRIS® Quarterly Statistics**
- **Additional Resources & State Newsletters**
- **Agency Descriptions**

NHCAA Anti-Fraud Initiatives Team

Member Organization or Law Enforcement personnel who need assistance or have questions regarding the SIRIS database, Requests for Investigation Assistance (RIAs), or other information-sharing activities should contact the NHCAA Anti-Fraud Initiatives team. Questions? Contact fraud@nhcaa.org.

MEMBER ORGANIZATION INTELLIGENCE

National

Improper mail order dispensing of FC2 female condoms

The Magellan SIU has identified a potential FWA scheme involving multiple mail order pharmacies (all associated with the same company) that specialize in birth control subscriptions prescribed through telehealth providers via the company's website. The communication between patients and providers reportedly takes place via text or messaging rather than a telehealth platform. Prescriptions are routed to an affiliated pharmacy and then transferred to another pharmacy for actual dispensing. Online patient reviews describe how patients receive an email from a pharmacy indicating they are eligible for the FC2. The FC2 is then added to the patient's subscription unless the patient specifically opts out. Patients report that the pharmacies are sending FC2 female condoms as part of the subscription and billing insurance without their consent nor have they specifically discussed them with a doctor.

Increase in Q-Code Billings

A substantial increase in improper billings Amniotic Fluid products/Q-Codes has been observed. This involves the improper billing of the Q-Codes for injections/pain management for Amniotic Fluid products which is beyond the intended use (wound care). The affected Q-Codes are listed below:

- Q4139-AmnioMAtrix or BioDMatrix, injectable, 1 cc
- Q4145-Epifix, injectable, 1mg
- Q4155-NeoxFlo or ClarixFlo, 1 mg
- Q4160-NuShield, per square centimeter
- Q4162-Woundex flow, bioskin flow, 0.5cc
- Q4168-Amnioband, 1 mg
- Q4171-Interfyl, 1mg
- Q4174-Palingen or promatrx, 0.36mg per 0.25cc
- Q4177-Floweramnioflo, 0.1cc
- Q4185-Cellesta flowable amnion (25 mg per cc); per 0.5 cc (Effective 01/01/2019)
- Q4189-Artacent ac, 1 mg (Effective 01/01/2019)
- Q4192-Restorigin, 1 cc (Effective 01/01/2019)
- Q4194-Novachor, per square centimeter (Effective 01/01/2019)
- Q4206-Fluid flow or fluid GF, 1 cc (Effective 10/01/19)
- Q4212-Allogen, per cc (Effective 10/01/19)
- Q4213-Ascent, 0.5 mg (Effective 10/01/19)
- Q4215-Axolotl ambient or axolotl cryo, 0.1 mg (Effective 10/01/19)
- Q4230-Cogenex flowable amnion, per 0.5 cc (Effective 7/1/20)
- Q4231-Corplex p, per cc (Effective 7/1/20)
- Q4233-Surfactor or nudyn, per 0.5 cc (Effective 7/1/20)
- Q4240-Corecyte, for topical use only, per 0.5 cc (Effective 7/1/20)
- Q4241-Polycyte, for topical use only, per 0.5 cc (Effective 7/1/20)
- Q4242-Amniocyte plus, per 0.5 cc (Effective 7/1/20)
- Q4244-Procenta, per 200 mg (Effective 7/1/20)
- Q4245-Amniotext, per cc (Effective 7/1/20)
- Q4246-Coretext or protext, per cc (Effective 7/1/20)

SPOTLIGHT ARTICLES

Blanket Allergy Testing & Antigen Immunotherapy Preparation

Submitted by Nicole Matty, AHFI, Lead Investigator, Oscar Health Inc.

Background: Oscar's Special Investigation Unit received several data analytics alerts showing spikes in allergy testing and immunotherapy preparation claims submitted by general practitioners in the South and Southeast Regions. The same data also revealed that impacted patients typically had no claims to support they ever received allergy injections. The CPT Codes at issue are 95004-95199.

Medical Records: Medical record reviews were performed and showed the following:

- Allergy testing was performed on patients the same day as unrelated E&M visits despite claims reporting testing occurred on different dates.
- Allergy testing was performed despite patient records confirming no prior allergy symptoms nor unsuccessful use of OTC medications; tests were often given to patients from the same household on the same day.
- Documentation submitted for allergy tests lacked any interpretation and report.
- Allergy test results were often marked valid when they were invalid due to the negative control response being greater than or equal to the positive control response.

- Documentation supported that test results were often sent to off-site third-party pharmacies for antigen preparation despite claims reporting the rendering provider was performing the services at the office location.
- Immunotherapy preparation notes conflicted with test results often showing allergens included in vials despite patients not testing positive to the allergen; the units billed were not supported.
- Progress notes indicated injections were to be provided for at-home administration despite at-home administration of subcutaneous immunotherapy (SCIT) injections not being a covered indication.

Patient/Provider Interviews:

- Members reported they sought care for unrelated health issues and were told allergy tests were either required, part of standard preventive testing, or were being provided free of charge.
- Members reported never receiving test results, never receiving information on immunotherapy, and never receiving or being scheduled for injections.
- Members reported they were not billed for their cost-share for tests or antigen preparation often involving hundreds or thousands of dollars per member.
- Office confirmed providers were not preparing antigens on-site and were not supervising the antigens being prepared elsewhere.
- Office confirmed they were waiving patient cost share and were relying solely on insurance reimbursement.

Gaming the System: Rehab Facilities Exploitation of Health Exchange Vetting Issues

Submitted by J. Hurley, CFI, Magellan Health SIU

The removal of exclusions for preexisting conditions from health insurance policies, combined with the requirement to treat substance abuse as a medical problem, continues to generate a significant increase in the number of private sober living homes and drug rehabilitation programs – collectively “rehab facilities”. While states are beginning to enact tougher regulations regarding these facilities, they are still playing catch up. While loopholes are tightened and certification standards are raised, non-medical entrepreneurs are trying to cash in on what is still viewed as a lucrative market.

Entrepreneurs increasingly utilize vague language in their charters, to not have to follow a specific business course. This is accomplished in states that allow charters to contain language permitting them to engage in “any and all lawful business” and do not prohibit the ownership of private medical facilities by non-medical individuals.

Many providers facilitate a flow of clientele by actively recruiting homeless and indigent people to seek treatment with them by offering to purchase/pay for healthcare coverage and waive co-pays and deductibles. According to the to the U.S. GAO Forensic Audits and Investigative Service, a lack of checks and controls in the health care exchanges continues to make it relatively easy to obtain health insurance policies through state health exchanges by fraudulent means. It has been noted that rehab facilities who conduct such activities tend to purchase private policies from commercial carriers through a state health exchange. This allows them to avoid restrictions and other legal entanglements inherent in federal programs; such, as Medicare or Medicaid.

Evidence has been developed indicating that rehab facilities have been exploiting the vulnerabilities in the state exchanges to their advantage. In addition, some of these facilities have resorted to additional questionable and/or fraudulent practices to cover the expense of their enticements, such as, double billing under multiple TIN’s while using modifier 59, billing for services not rendered, the use of unlicensed/non-certified practitioners, and violating state self-referral statutes. In particular, this has become a growing issue in the states of California and Florida, which do not restrict the ownership of private medical facilities to licensed medical personnel. In addition, many providers commit additional self-referral violations. This occurs when they set up laboratories for blood and urine testing, which they own, and direct all testing from their facilities to these laboratories.

In one case, it was confirmed that a California based rehab facility engaged in the aforementioned activities. The facility in question purchased policies from commercial carriers, without patients' knowledge or consent, despite the fact that some already had coverage through Medicare/Medicaid, which resulted in tax liability issues for those patients. All blood and urine analysis were subsequently directed to a laboratory owned by the individual who owned the rehab facility. The provider in question was found to have engage in billing for services not rendered and double billing, as well as identity fraud.

The aforementioned provider shopped for polices through various state exchanges finally settling on a carrier that required the purchaser to reside in one of two states, neither of which was where they resided and/or where the provider was located. The provider tested this particular state's health exchange vetting and security by utilizing the same false in-state address for two clients. Once these policies were successfully issued, policies were purchased for two more members utilizing an "out-of-state" address in a nearby state. While the first two policies used an actual residential address, the out-of-state policies utilized a private post office box at a UPS Store. That address was formatted to appear as if it were an apartment or condominium by listing the "Box" number as a "Suite" number. Once these policies were successfully issued, the provider then used its own private post office box at a UPS Store in California to purchase numerous additional policies.

In the initial investigation, the member addresses for the aforementioned policies were canvassed via Google Streets/Earth and the aforementioned information was confirmed. However, national comprehensive reports for them revealed that most did not reside in California or the states utilized in securing polices.

A comprehensive claims review was subsequently conducted to determine if the provider was engaged in the aforementioned suspect activities. A review of every patient's carrier assigned patient ID number revealed that there were sequential identification numbers in groups ranging from 2 to 14 numbers. Of the 88 numbers listed, only 16 were not in direct sequential order. However, of those numbers, 4 were within 2 digits of an adjoining number and 6 were within 3 digits of each other. As such, only 6 of the numbers were not in direct or proximate sequence with each other. However, all were contained within the same overall number range. The statistical improbability of such a numeric sequence occurring randomly was noted. Of the policies in question, all were taken out through the same state health exchange where the applicants did not live, despite residency in said state being a requirement. Additionally, these individuals sought treatment during the same year at the same rehab facility.

The plan's records check revealed that four business entities in the provider's network had received benefit payments. One of these entities was in Colorado while the remaining three were California. The combined claims history for all four revealed that many of the patients had paid claims with two or three of the providers on the same dates. In addition, three had treatment with all four providers on the same date. Again, one of the providers was located in Colorado.

The initial working sample contained polices that were issued and terminated in 2016. The average policy life was 198 days or 6.6 months. The average time between incept and use of benefits was 15 days. With respect to the polices issued by the carrier in question, the ID numbers were issued sequentially at the time of application. Therefore, the sequences identified indicate that multiple policies were programmed one after the other and most likely by the same operator or group of operators.

Reports from the National Comprehensive Report were run on the provider, and they identified the owner, CEO, and corporate officers. Individual National Comprehensive Reports were run on them, which revealed approximately 20 additional businesses in which they were involved. A significant portion of these were medical or medically related. Additional National Comprehensive Reports were pulled on the various businesses and their information was checked against Magellan's internal records, CMS, and the corporate filings for the states in which they were formed. Four additional businesses were identified in internal records of which three had paid claims. Out of the four paid providers, three were in California and one was in Colorado.

While investigating the 21 businesses associated with the provider's owner, a direct link was found to a similarly structured provider group in Florida. This was by way of a shared Resident Agent. It was noted that the owners of the Florida group had medically related businesses and several former non-medical businesses, some of which were still active.

When faced with such allegations, it is important to handle the matter primarily as a business investigation. The below listed initial investigative steps will aid in determining if the allegation is correct and a business investigation should be initiated or if other matters are occurring. They will also help you determine if the policies or groups of policies were taken out on the same date and by the same operator or group of operators. If possible, have your IT personnel track the IP address from where the requests originated. Also, have your finance department trace the source of the premium payments to determine if they come from a single payer or a defined group of payers.

- Review policy information to determine if the insureds have:
    - sequential policy numbers
    - sequential patient ID numbers
    - similar or sequential social security numbers
    - share the same or similar addresses
- Determine the full range of any sequential numbers.
- Identify the groups and/or clusters of sequential numbers within the range.
- Determine the effective dates of the policies.
- Determine the average time lapse between the policy effective date and the first use of benefits. An average use date of 15 days or less is indicative of it being obtained as the result of recruitment/inducement.
- Determine the average policy life in days. A policy lasting six months or less is also indicative of it being obtained as the result of recruitment/inducement
- Determine if there were other non-rehab related claims presented. A lack of such claims is also indicative of the policy being obtained as the result of recruitment/inducement.
- Secure National Comprehensive Reports on the patients to determine if they are real people and if so, their true addresses and contact information.

If all or most of the above steps reveal positive results, then a full business investigation into the provider, its owners, officers, and related businesses should be conducted.

- Identify the owners and officers of the provider by conducting records checks via:
    - The local Secretary of State - Division of Corporations
    - State Department of Assessments and Taxation
    - Uniform Commercial Codes Office.
- Secure and review all business charters, amendments, and financing statements. These will reveal:
    - Current and former owners & officers
    - Business addresses
    - Related businesses
    - Business TIN's (in some states)
    - Expansion/conversion language that allows a business entity to change from its initial stated business purpose. (i.e.) "and any other lawful business"
- Secure national comprehensive reports and/or other business reports regarding the known business entities, its owners and officers. These may reveal additional businesses, addresses, and clarify officer's positions within the business.
- Check federal records for exclusions pertaining to the business owners and officers.
- Check for the appropriate state licenses for the businesses and their personnel. Just because they are properly chartered, doesn't mean they are legally allowed to provide any service they choose.
- Determine if the business owners or officers are linked/related to other providers who are under investigation or should be reviewed for additional action.

- Conduct general internet and court record searches on the businesses, as well as their owners and officers for additional information.
- Run all TIN's and/or NPI's through your internal records to determine what, if any, claims are being presented or paid under them.
    - Secure a claims history report on all paid providers.
    - Review claims reports for multiple treatments by the multiple providers on the same dates.

Once you have completed the above steps, determine your exposure. Then you can decide if additional investigation is warranted.

Panel Issues

Submitted by Brian Signorelli, RN, Investigator II, Anthem, Inc.

"Panel" labs are designed primarily by the lab equipment manufacturer, with new exceptions emerging from the lab itself. They develop "panels" which lack any accepted published source, best practice guidelines, clinical support, or any documentation to support the included targets as a common syndrome. These "panels" have no seasonal, regional, current community infection, or any other variable. In the words of one Medicare LCD – "We find these "panel" labs to be neither reasonable nor necessary". Read that again.

In October 2016, the FDA granted a particular lab, referred to as Lab X moving forward, low complexity status. This was followed immediately by CLIA waived status and made retroactive in January 2017 by CMS assigning 87633QW for billing the "panel". CPT code 87633, by definition, is a Respiratory Viral Panel. The FDA 510(k), CLIA, and CMS listed the defined targets of 87633QW as 11 Viral and 3 Bacterial. The Lab X literature, widely available, lists the capability of the Lab X as inclusive of the bacterial targets Mycoplasma Pneumonia, Chlamydia Pneumonia, and Bordetella. As a matter of routine, claims filing and documented in educational material provided by Lab X (also available in their provider manuals), providers submit claims for the inclusive bacterial pathogens in addition to the 87633QW targets, and labs do the same when billing for Respiratory Pathogen Panel (RPP). These are billed using CPT codes 87486, 87581, and 87798. The lab submitted one claim for payment from another state with over 35 lines per claim. This constitutes unbundling.

The number and scope of these "panels" are on the rise. They are designed to not trip alarms by Medically Unlikely Edits (MUE), the National Correct Coding Initiative Program (NCCI), or any fed/state/local "same member/same DOS" or other CLIA edits. A high percentage of these Lab X unbundled claims could be stopped by a same DOS 87633/87486/87581/87798 edit. These are NOT included in MUE/NCCI or CLIA edits as it would be reasonable for a practitioner, ordering individualized labs specific to the patient/presentation, to combine these very labs. Adding CLIA Certification Type could also prove effective. Many of the pathogens, inclusive to the same "panel", have differing presentations which renders some of them mutually exclusive when chief complaint, history of present illness, medical history, assessment, medical decision-making, differential diagnosis, current community pathogen exposure, and sound clinical skills/critical thinking are used.

Title XVIII of the Social Security Act, §1862(a)(1)(A) allows coverage and payment for only those services that are considered to be reasonable and necessary.

Should We Be Concerned About Single-Source Medications/Manufacturers Contracting with Single-Source Dispensers?

Submitted by Blue Cross Blue Shield Association FEP Special Investigations Unit (FEP SIU)

While there are a number of legitimate reasons that these types of circumstances may exist, it is a utilization trend that is worth monitoring. SIU teams should consider reviewing these instances to ensure that there are legitimate reasons for such focused collaborations and utilization patterns.

There is a fraud-based history for this type of collaboration. Following an extensive review of dispensing practices, a PBM referred a case which resulted in the indictment and ultimate conviction (2016) of the CEO of an independent pharmacy and a Senior Executive of a drug manufacturer wherein the two colluded with the pharmacy to dispense, exclusively and fraudulently, the manufacturer's product line.

There are at least two ongoing matters and investigations with similar concerns. The first involves a common vitamin product used to treat deficiency and anemia - which is available in multiple routes of delivery - wherein a new nasal spray version is associated with an extremely large cost for insurers. The second product consists of a new delivery system for a generic and OTC nasal steroid agent. This product commands 70% of all fills for one suspect pharmacy and is also associated with extremely large costs for insurers.

These types of situations require that fraud teams stay alert and continue to monitor the usage and legitimacy of the claims.

GOVERNMENT LIAISON UPDATE

Agency Priorities

HHS-OIG

- **OIG Work Plan:** The OIG Work Plan sets forth various projects that are underway or are planned to be addressed during the fiscal year and beyond by OIG's Office of Audit Services and Office of Evaluation and Inspections. OIG's work portfolio also includes legal and investigative activities related to high-risk HHS programs that are the most in need of attention.

  OIG Work Plan updates are now made on a monthly basis to ensure that it more closely aligns with the work planning process. Adjustments are made throughout the year to meet priorities and to anticipate and respond to emerging issues with the resources available.

  The most current OIG Work Plan update can be found at: https://oig.hhs.gov/reports-and-publications/workplan/index.asp.

- **Summary of OIG Priorities:** For fiscal year 2021, OIG has set performance targets for the following priority areas: improving emergency preparedness and COVID-19 response and recovery; reducing risks to beneficiaries from substance use disorder; addressing opioid addiction, substance abuse treatment, and serious mental illness; promoting patient safety and accuracy of payments for services furnished in home and community settings; strengthening Medicaid effectiveness and protections against fraud, waste, and abuse; strengthening HHS cybersecurity protections for systems and data; and ensuring the health and safety of children served by grant-funded programs. Additional key oversight areas include prescription drug spending, managed care and non-traditional healthcare models, management of grants and contracts, oversight of technology, financial stewardship of HHS programs, the Indian Health Service and other programs serving American Indians and Alaska Natives, and HHS's emergency preparedness and response.









In light of the ongoing developments related to COVID-19, OIG continues to mobilize its staff and resources to address the many and varied issues arising from this public health emergency. OIG's top priority is to protect the public and the health and well-being of HHS program beneficiaries. This duty is all the more important as we confront the COVID-19 pandemic. To that end, OIG has published work addressing hospital preparedness, State agency approaches to childcare, and health care facility and community-level emergency response.

OIG's COVID-19 oversight strategic plan sets forth four goals: protecting people, protecting funds, protecting infrastructure, and promoting program effectiveness now and into the future. OIG accelerated efforts to initiate data-driven reviews examining the effectiveness of the public health response through an independent and objective lens.

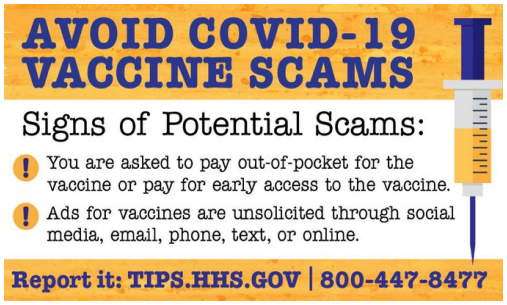
Consistent with Congress' call for transparency and oversight of the Federal COVID-19 response and funding, OIG continues to coordinate closely with the Pandemic Response Accountability Committee (PRAC) and other OIGs from multiple Departments responsible for the COVID-19 response.

As the oversight agency for HHS, OIG promotes the effectiveness of HHS's COVID-19 response and recovery efforts. OIG remains committed to protecting the millions of beneficiaries across the country and supporting the dedicated health care professionals who are working so hard to serve the public during this pandemic. To stay up to date on OIG's latest work related to COVID-19, click on the portal boxes appearing above.

Please note that OIG's COVID-19 Portal has been redesigned and features additional resources, including a searchable list of our COVID-19 reports and downloadable graphics. The portal provides news, alerts, reports, enforcement actions, policies & guidance, and outreach resources. The redesigned features include clear tabs for all of our work related to COVID-19 in one central place. These pages describe our COVID-19 work agency wide.

OIG Outreach: OIG is committed to keeping the public informed about general fraud schemes related to COVID-19 vaccines, health care services, and HHS grant scams. OIG mitigates the harm from these schemes by proactively alerting the public about potential scams and instructing people how to protect themselves. Appearing below are examples of OIG's outreach efforts to the general public.

WHAT'S TRENDING



VACCINE SCAMS

Fraudsters are offering COVID-19 tests, HHS grants, and Medicare prescription cards in exchange for personal details, including Medicare information. These services are unapproved and illegitimate. Protect yourself from potential #COVID19 vaccine scams. To learn more visit: https://t.co/yUqs6sxEM5?amp=1



COVID VACCINE PAYMENT

HHS-OIG reminds vaccine providers and the public that the COVID-19 vaccine is being provided by the Federal Government and must be administered at NO COST to recipients. To learn more visit: http://www.go.usa.gov/xHWs2.



COUNTERFEIT VACCINE CARDS

Vaccine cards can be easily faked, but not the information behind them. Creating, using, and selling counterfeit COVID-19 vaccination cards are considered illegal activities and adversely impacts ongoing pandemic response efforts. Penalties for forging a vaccine card carries a penalty of up to 5 years in prison.



CYBERSECURITY

The increased targeting of HHS, health care organizations, and several entities that are important to the COVID-19 response demonstrates the importance of prioritizing cybersecurity. For HHS-OIG, cybersecurity is a fraud, waste, and abuse issue. To learn more visit: https://go.usa.gov/xHFNq

- **New Features Added to HHS-OIG Fugitives Website Portal**
  In February 2021, OIG introduced a new feature to its fugitive website portal that now allows users to Report a Fugitive Sighting. The other new feature adds new search capabilities to the Fugitives photographs and descriptions section that allows users to search by fugitive type and status.

- On April 9, 2021, Principal Deputy Inspector General (PDIG) Christi A. Grimm and Chair of the Pandemic Response Accountability Committee (PRAC) Michael E. Horowitz co-authored an Op-Ed titled "Four crucial lessons for improving Covid-19 testing," for the CNN Opinion website.

- On April 19, 2021, PDIG Christi Grimm gave the keynote speech at the Health Care Compliance Association Annual Compliance Institute, offering her insights about compliance, COVID-19, telehealth, nursing homes and other topics. Click on the following links to access related materials: Presentation, Transcript, Handout.

- On April 22, 2021, Gary Cantrell, Deputy Inspector General for Investigations (DIGI), testified before the Congressional Committee on Health, Education, Labor and Pensions to discuss how HHS-OIG is diligently working, in conjunction with its HHS and law enforcement partners, to protect taxpayer funded medical research. DIGI Cantrell's testimony can be accessed here: Testimony on Protecting U.S. Biomedical Research: Efforts to Prevent Undue Foreign Influence.

- In May 2021, OIG released *Toolkit: Insights from OIG's Work on the Office of Refugee Resettlement's Efforts to Care for Unaccompanied Children*. The toolkit compiles insights from OIG's years of oversight of this program and was intended to assist ORR in responding to the latest surge of unaccompanied children and included immediate actions ORR could take to ensure children's health and safety.

  Here's a link to the body of completed OIG audits and evaluations related to the Unaccompanied Children Program: Unaccompanied Children | HHS-OIG.

  OEI-09-21-00220 | Complete Toolkit

- On June 29, 2021, PDIG Christi Grimm provided and update on OIG's oversight of COVID-19-related programs at the American Health Law Association Annual Meeting. A full transcript of PDIG Grimm's keynote address can be found here.

- **OI Priorities:** For fiscal year 2021, OI will continue to leverage modern data analytics and state-of-the-art investigative techniques to identify and target potential fraud schemes and areas of program waste and abuse. OI's top investigative priorities continue in the following areas: COVID-19 fraud schemes; CARES Act fraud schemes related to the Provider Relief Fund and HRSA's COVID-19 Uninsured Program; controlled and non-controlled prescription drug fraud; home and community-based services to include Medicare home health fraud schemes and Medicaid personal care services fraud schemes; ambulance transportation fraud; durable medical equipment fraud; diagnostic radiology and laboratory testing fraud; telemedicine fraud; genetic testing fraud; and Office of Refugee Resettlement oversight of the Unaccompanied Children (UC) Program.

COMBATTING FRAUD & ABUSE



On July 21, 2021, HHS-OIG updated its COVID-19 Fraud Alert with new information relating to COVID-19 vaccines and emerging fraud schemes.

Early in the pandemic, OIG issued a Fraud Alert warning the public about bad actors who were preying on people's fears for profit, perpetrating fraud schemes, including marketing fake COVID-19 test kits and unapproved treatments through telemarketing calls, social media platforms, and door-to-door visits.

This updated alert focuses on how fraudsters continue to perpetrate COVID-19-related scams by offering COVID-19 tests, HHS grants, and Medicare prescription cards in exchange for personally identifiable information, including Medicare information. These services are unapproved and illegitimate.

These scammers use the coronavirus pandemic to benefit themselves, and beneficiaries face potential harm. The personal information collected can be used to fraudulently bill Federal health care programs and commit medical identity theft.

OIG will regularly update the alert with the latest information about scams that exploit the pandemic, aiming to defraud Medicare and Medicaid beneficiaries and the Federal health care programs that serve them. The update also provides general information on how to protect oneself and the community against bad actors.

COVID-19 Vaccine Scams Press Release: On December 21, 2020, the Federal Bureau of Investigation (FBI), HHS-OIG, and Centers for Medicare & Medicaid Services (CMS) issued a Vaccine Scams Press Release warning the public about several emerging fraud schemes related to COVID19 vaccines. The FBI, HHS-OIG, and CMS have received complaints of scammers using the public's interest in COVID-19 vaccines to obtain personally identifiable information (PII) and money through various schemes. OIG continues to work diligently with its law enforcement partners and the private sector to identify cyber threats and fraud in all forms.

Special Fraud Alert–Speaker Programs: On November 16, 2020, OIG released a Special Fraud Alert highlighting fraud and abuse risks in the offer, payment, solicitation, or receipt of remuneration related to speaker programs hosted by pharmaceutical and medical device companies. OIG urged drugmakers and medical device companies to avoid soliciting and paying physicians to speak on their behalf.

The alert is the first one issued by OIG in 6 years, and it comes as several drugmakers have found themselves ensconced in kickback-related litigation, which include cases involving Purdue Pharma and Alexion.

Purdue Pharma's October 21. 2020, $8.3 billion settlement involved allegations it paid physicians to encourage other healthcare professionals to prescribe more of its opioids. On July 2, 2020, Alexion agreed to pay more than $21 million to settle the Securities and Exchange Commission's allegations it used bribes to improve sales of its blood disease drug Soliris in Russia and Turkey.



Operation CARE: In November 2020, OIG launched a new webpage dedicated to the prevention and reporting of fraud, abuse, and neglect in elder care settings. The page provides resources to support the public in acting as advocates for the elder population.

The page stems from OIG's recent nursing home national outreach and awareness campaign, Operation CARE. The initiative aimed to encourage nursing home and emergency medical service staff to use best practices during the COVID-19 pandemic and report instances of suspected elder harm.

HHS-OIG Report on COVID-19 Impact on Medicare/Nursing Homes: On June 22, 2021, HHS-OIG issued a report titled: *COVID-19 Had a Devastating Impact on Medicare Beneficiaries in Nursing Homes During 2020*. The report provides useful statistical information on the oversized impact the COVID-19 pandemic had on Medicare beneficiaries in nursing homes. To download a pdf of the complete 12-page report, click here.

CMS Survey Agency Oversight Update: CMS intends to resume "normal" Survey Agency (SA) oversight roles/responsibilities in nursing homes that were relaxed during the public health emergency (PHE). Throughout the PHE, CMS and SAs have been unable to have the traditional level of visibility inside nursing homes to assess residents' health and safety, and survey for facilities' compliance. Due to the limitations of oversight during the PHE and changes in how some nursing homes may have operated, there is concern about how residents' health and safety has been impacted, such as increased weight loss, pressure ulcers, abuse or neglect, and other quality of care and quality of life issues.

OIG Office of Investigations Engagement with Nursing Home Advocacy Groups: In June 2021, the OIG Office of Investigations engaged with nursing home advocacy groups that raised concerns related to fraud, waste, and abuse occurring in the nursing home setting. Following are the main concerns that were raised:

- Typically, temporary nurse aides (TNAs) are required to complete a certain number of training hours. However, during the pandemic, training requirements were relaxed, and the concern is that once the PHE ends some TNAs may continue to provide care without the appropriate training, or continue to perform duties under inadequate supervision.

- During the PHE there has been a significant increase in the administration of psychotic and psychotropic drugs in nursing homes (especially during the second quarter of the pandemic).

- Problematic facility-initiated discharges appear to act in a manner that capitalizes on billing opportunities related to housing of COVID patients.

- **Strike Force Operations:** The Health Care Fraud Strike Force (Strike Force) model is comprised of interagency teams made up of investigators and prosecutors that focus on the worst offenders in regions with the highest known concentration of fraudulent activities. The Strike Force uses advanced data analysis techniques to identify aberrant billing levels in health care fraud hot spots—cities with high levels of billing fraud—and target suspicious billing patterns, as well as emerging schemes and schemes that migrate from one community to another. Data analytics will continue to be the driver for health care fraud investigations.

  Since its inception in March 2007, the Strike Force, which maintains 15 strike force teams operating in 24 districts, has charged nearly 4,000 defendants who have collectively billed the Medicare program for more than $14 billion. In addition, the HHS Centers for Medicare & Medicaid Services (CMS), working in conjunction with HHS-OIG, are taking steps to increase accountability and decrease the presence of fraudulent providers through invoking administrative actions.

  Coordinated enforcement takedowns involving Federal, State, and local agencies will continue to be part of the government's anti-fraud enforcement arsenal and a centerpiece in the fight against opioid epidemic. The allocation of the hundreds of OIG special agents and other law enforcement personnel is a clear indication of the DOJ's and OIG's commitment to combating fraud in the Federal health care programs.

  Takedowns protect Medicare and Medicaid and deter fraud—sending a strong signal that theft from these taxpayer-funded programs will not be tolerated. The money taxpayers spend fighting fraud is an excellent investment: For every $1 spent on health care-related fraud and abuse investigations in the last 3 years, more than $5 has been recovered.

  An in-depth description of the Strike Force program, its statistical successes, and ongoing investigative activities can be found at: https://oig.hhs.gov/fraud/strike-force/

STRIKE FORCE LOCATION & OPERATIONS OVERVIEW

In CY 2018, HHS-OIG, in partnership with the U.S. Department of Justice (DOJ), the Federal Bureau of Investigation (FBI), and the Drug Enforcement Administration (DEA) expanded Strike Force operations to two additional regions. In August 2018, HHS-OIG and its partners formed the *Newark/Philadelphia Medicare Fraud Strike Force*, which focuses on health care fraud and illegal opioid prescriptions in the Newark/Philadelphia region. In October 2018, HHS-OIG and its aforementioned partners also created the *Appalachian Regional Prescription Opioid (ARPO) Strike Force* to focus on illegal opioid prescriptions covering nine Federal districts in five States. The mission of the ARPO Strike Force is to identify and investigate health care fraud schemes in the Appalachian region and surrounding areas, and to effectively and efficiently prosecute medical professionals and others involved in the illegal prescription and distribution of opioids. *[See map below depicting all current Strike Force locations.]*



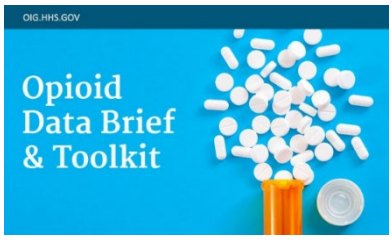
Formed in October 2018, the ARPO Strike Force operates in Cincinnati, Louisville, Pittsburgh, Knoxville, Memphis, and Birmingham to investigate illegal opioid prescriptions in the surrounding areas. The ARPO Strike Force is made up of prosecutors and data analysts with the Health Care Fraud Unit of DOJ's Criminal Division Fraud Section, prosecutors with the U.S. Attorney's Offices in the region and special agents with the FBI, HHS-OIG, and DEA. Engaging partnerships include the Center for Disease Control's (CDC) Opioid Rapid Response Program (ORRP) team and State public health partners to address disruptions in patient care after takedown. CDC ORRTs provide clinicians with resources, expand access to medication-assisted treatment, and help build response capacity.

Opioid Rapid Response Program (ORRP): HHS's ORRP team is designed to strengthen Federal, State, and local response across the country. Disrupted access to a prescriber can negatively impact patients with physical opioid dependence. Prior to a law enforcement action, the ORRP team is provided with information that can help them assess patient risk and target resources to mitigate the risk of overdose among patients of an opioid prescriber subject to a pending law enforcement action.

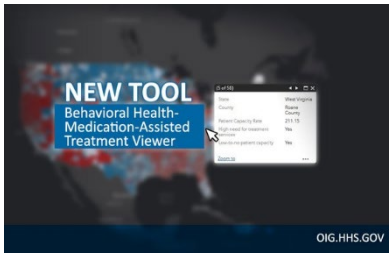
The program began under the leadership of a senior medical officer at CDC who collaborated with the U.S. Public Health Service and many Federal and State law enforcement officials who were part of the Appalachian Regional Prescription Opioid Strike Force Takedown in 2018. ARPO began to combat the opioid overdose epidemic by identifying, investigating, and effectively and efficiently prosecuting medical professionals involved in the illegal prescription and distribution of opioids in these six states. In coordination with ARPO, ORRP (then known as Opioid Rapid Response Teams) was initiated.

Today ORRP establishes “trusted contacts” within each State, to which information about impending actions can be provided at the time or prior to an action without compromising operational security. Trusted contacts may take immediate steps to further assess patient risk and prepare to put mitigation measures in place to decrease overdose risks.

More information regarding the work ORRP does can be found at: https://www.cdc.gov/opioids/opioid-rapid-response-program.html.



HHS-OIG has developed two toolkits to identify certain patients at risk of #opioid misuse or overdose. The toolkits assist the public and private sectors with analyzing prescription drug claims data to help combat the opioid crisis. Learn more: https://go.usa.gov/xFaqm.



Data from the new HHS-OIG tool provides information to help make decisions for improving access to medication-assisted treatment for those with opioid use disorder.

The Behavioral Health–Medication-Assisted Treatment Viewer, is an interactive web application that allows users to explore data related to the opioid epidemic. With the comprehensive data obtained from this tool, stakeholders can conduct additional analysis to make decisions for improving access to medication-assisted treatment for people with opioid use disorder.

COVID-19 Fraud Task Force Announced and Convened: On May 17, 2021, U.S. Attorney General Merrick Garland announced the creation of the COVID-19 Fraud

Enforcement Task Force, a multi-agency effort organized and led by the Deputy Attorney General at the Department of Justice (DOJ). The Task Force is aimed at marshalling the resources of DOJ in partnership with agencies across government to enhance enforcement efforts against COVID-19 related fraud. Creation of the Task Force will augment the work that is already underway.

Additional information about the COVID-19 Fraud Enforcement Task Force, which includes Task Force member and enforcement actions, can be found on the Fact Sheet that accompanied the announcement.

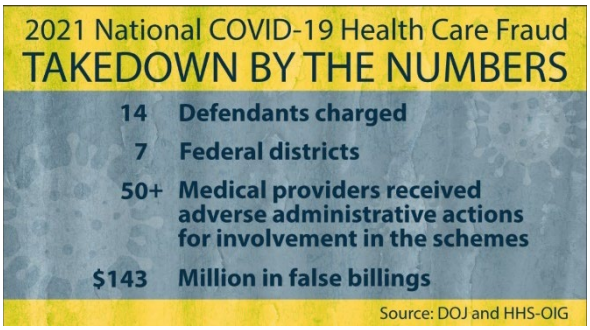
Download AG Memorandum

2021 NATIONAL COVID-19 HEALTH CARE FRAUD TAKEDOWN

In May 2021, HHS-OIG, along with its law enforcement partners, participated in the largest coordinated law enforcement action to combat health care fraud related to COVID-19.



The takedown focused on several schemes involving multiple defendants who offered COVID-19 tests to Medicare beneficiaries at senior living facilities, drive-through COVID-19 testing sites, and medical offices to induce the beneficiaries to provide their personal identifying information and a saliva or blood sample. The defendants are alleged to have then misused the information and samples to submit claims to Medicare for unrelated, medically unnecessary, and far more expensive laboratory tests, including cancer genetic testing, allergy testing, and respiratory pathogen panel tests. Instead of providing needed health care services during this unprecedented time in our country, the defendants alleged fraudulent activities took advantage of the COVID-19 pandemic to victimize beneficiaries, steal from Federal health care programs, and line their own pockets.



This fraudulent activity resulted in charges against 14 defendants in seven Federal districts across the United States charged for their alleged participation in various health care fraud schemes that exploited the COVID-19 pandemic and resulted in over $143 million in false billings. Defendants include telemedicine company executives, physicians, marketers, and medical business owners.

DOJ Press Release
Download a PDF of the Scheme

Case Highlights

FBI

COVID-19

- **Medical Clinic and Medical Transport Fraud:** On May 27, 2020, the United States Attorney's Office, District of Arizona, unsealed three criminal complaints filed in Federal District Court charging multiple individuals with health care fraud associated with the COVID-19 pandemic. The matter was investigated by a COVID-19 Fraud Task Force, which included the FBI, Health and Human Services Office of the Inspector General (HHS-OIG), and the Arizona Health Care Cost Containment System Office of the Inspector General (AHCCCS-OIG).

  One complaint charged Jeremiah Faber, 45, of Gold Canyon, Arizona, the CEO of Harmony Healthcare, LLC dba Harmony Medical Care, with one count of health care fraud and one count of money laundering. The complaint alleged Faber used Harmony's Facebook and other social media sources to offer free COVID-19 testing if patients also completed Harmony's Comprehensive Whole-Body Assessment. Harmony then fraudulently submitted claims for reimbursement to Mercy Care, Arizona's health care benefit program, by billing for services that were medically unnecessary and for services provided in the names of physicians who had no role in the assessment.

  Two other complaints charged a total of six individuals associated with five Phoenix-area businesses that purported to provide non-emergency medical transportation services on the Navajo Nation. The first complaint charged Abdul Raheem Abdul Jabbar, Nohad Loabneh, and Abedelhalim Lawabni with conspiring to commit health care fraud. The complaint alleged that Abdul Jabbar, Loabneh, and Lawabni falsely billed Arizona's Health Care Cost Containment System (AHCCCS) for more than 9,000 non-emergency medical transports in April 2020 when those transports never occurred. After the Arizona Governor and the President of the Navajo Nation both declared COVID-19 public emergencies, the need for non-emergency medical transports dramatically decreased. The complaint further alleges that their false billings in April 2020 generated a total of more than $2.75 million in fraudulent payments from AHCCCS to the three businesses. AHCCCS is Arizona's Medicaid agency, offering health care programs to low-income Arizona residents. Loabneh, and Lawabni own and operate A&N Services, LLC. Abdul Jabbar owns and operates Freedom AZ, LLC, and is also affiliated with Desert Mobile, LLC.

  The second complaint charged Miguel Denga, Husam Alsadi, and Tamarria Denga with conspiring to commit health care fraud. The complaint alleged that Alsadi and the Dengas falsely billed AHCCCS for more than 1,500 non-emergency medical transports in April 2020 when those transports never occurred. As noted above, after the Governor of Arizona and the President of the Navajo Nation both declared COVID-19 public emergencies, the need for non-emergency medical transports dramatically decreased. The complaint further alleges that their false billings in April 2020 generated a total of more than $450,000 in fraudulent payments from AHCCCS to the two businesses. Miguel Denga and Alsadi own and operate Philia Homecare, LLC. Tamarria Denga owns and operates COS 1, LLC.

Qui Tam FBI Case Highlight

- **Novartis Pays Over $642 Million to Settle Allegations of Improper Payments to Patients and Physicians:** As of July 1, 2020, pharmaceutical company Novartis Pharmaceuticals Corporation (Novartis), based in East Hanover, New Jersey, has agreed to pay over $642 million in separate settlements resolving claims that it violated the False Claims Act (FCA). The first settlement pertains to the company's alleged illegal use of three foundations as conduits to pay the copayments of Medicare patients taking Novartis's drugs Gilenya and Afinitor. The second settlement resolves claims arising from the company's alleged payments of kickbacks to doctors.

The Anti-Kickback Statute prohibits anyone from offering or paying, directly or indirectly, any remuneration — which includes money or any other thing of value — to induce referrals of items or services covered by Medicare, Medicaid, and other federally funded programs. This prohibition extends not only to improper payments to providers, but also to the improper payment of patients' copay obligations.

In the first settlement, Novartis has agreed to pay $51.25 million to resolve allegations that it illegally paid the copay obligations for patients taking its drugs. When a Medicare beneficiary obtains a prescription drug covered by Medicare, the beneficiary may be required to make a partial payment, which may take the form of a copayment, coinsurance, or a deductible (collectively "copays"). Congress included copay requirements in the Medicare program, in part, to serve as a check on health care costs, including the prices that pharmaceutical manufacturers can demand for their drugs.

Novartis sells Gilenya, which is approved for treatment of relapsing forms of multiple sclerosis (MS). The government alleged that, in October 2012, Novartis learned from the contractor managing Novartis's free drug program for Gilenya that over 300 patients who were receiving free drugs would be eligible for Medicare in 2013. Novartis and the contractor transitioned those patients to Medicare Part D so that, in the future, Novartis would obtain revenue from Medicare when those patients filled prescriptions for Gilenya. Knowing those patients could not afford the copay for Gilenya, Novartis developed a plan with a foundation so that Novartis could cover the copays for those patients. Specifically, at the same time Novartis made a payment to the foundation, Novartis arranged for the foundation to open its MS fund at 6:00 pm on a Friday and for the contractor to have personnel working overtime to submit applications for those patients who had been receiving free Gilenya. Novartis knew that this coordination would result in a disproportionate share of its funding going to Gilenya patients for 2013.

Novartis also sells Afinitor, which is a second-line treatment for advanced renal cell carcinoma (RCC) and a treatment for progressive neuroendocrine tumors of pancreatic origin (PNET). The government alleged that Novartis learned that, for the 2010 donation year, it would be the only donor to an RCC copay assistance fund operated by a charitable foundation. The government alleged that Novartis told the foundation that it would be willing to donate to the fund only if the eligibility definition was narrowed in a way that ensured that a greater amount of the copay assistance would support patients taking Afinitor. The government alleged that, as a result of narrowing the fund definition, the fund disproportionately assisted patients taking Afinitor compared to its overall usage rate among RCC drugs.

The government further alleged that, in 2012, Novartis asked another foundation to open a copay assistance fund to pay copays for PNET patients, which Novartis knew would be used only to pay the copays of Afinitor patients.

In the second matter, Novartis will pay $591,442,008 to resolve FCA claims that it paid kickbacks to doctors to induce them to prescribe the Novartis drugs Lotrel, Valturna, Starlix, Tekturna, Tekturna HCT, Tekamlo, Diovan, Diovan HCT, Exforge, and Exforge HCT. In addition, Novartis will forfeit $38.4 million under the Civil Asset Forfeiture Statute. Novartis also made extensive factual admissions in the settlement and agreed to strict limitations on any future speaker programs, including reductions to the amount it may spend on such programs.

In a case pending in the Southern District of New York, the United States alleged that Novartis hosted tens of thousands of speaker programs and related events under the guise of providing educational content, when in fact the events served as nothing more than a means to provide bribes to doctors. Novartis paid physicians honoraria, purportedly as compensation for delivering a lecture regarding a Novartis medication, but, as Novartis knew, many of these programs were nothing more than social events held at expensive restaurants, with little or no discussion about

the Novartis drugs. Indeed, some of the so-called speaker events never even took place; the speaker was simply paid a fee to induce the speaker to prescribe Novartis drugs.

The government's complaint further alleged that Novartis sales representatives, on the instruction of their managers, selected high-volume prescribers to serve as the paid "speakers" at these events with the intent to induce them to write more — or keep writing many — Novartis prescriptions. The sales representatives then pressured the speakers to increase their prescriptions of Novartis drugs, and often dropped doctors from the speaker program if they failed to do so. Further, the government alleged that this widespread kickback scheme was the result of decisions made by top management at Novartis's North American headquarters in New Jersey.

This settlement resolves a lawsuit captioned United States ex rel. Bilotta v. Novartis Pharmaceuticals Corp., No. 11-Civ.-0071-PGG (S.D.N.Y.) initially filed under the whistleblower provision of the FCA, which permits private parties to file suit on behalf of the United States for false claims and share in a portion of the government's recovery. The FCA permits the United States to intervene in such a lawsuit, as it did in the whistleblower case filed against Novartis. The amount to be recovered by the private whistleblower, Oswald Bilotta, has not yet been determined. As part of the settlement, Novartis will also pay an additional $48,151,273 to resolve state Medicaid claims.

Contemporaneous with the settlement of the FCA claims in these matters, Novartis entered into a corporate integrity agreement (CIA) with the Department of Health and Human Services Office of Inspector General (HHS-OIG). The five-year CIA addresses the conduct at issue in both matters. Among other things, the CIA requires Novartis to significantly reduce the number of paid speaker programs and the amounts spent on such programs. Under the CIA, Novartis speaker programs may only occur under limited circumstances and in a virtual format. In addition, the CIA requires Novartis to implement measures designed to promote independence from any patient assistance programs to which it contributes. The CIA also requires multi-faceted monitoring of Novartis's operations and obligates company executives and Board members to certify about compliance.

The FBI, Department of Health and Human Services, Office of Inspector General and the Department of Defense, Office of Inspector General participated in the Novartis matter.

HHS-OIG

COVID-19

- **Colorado Physician Charged for Misappropriating Thousands from Three Different COVID Relief Programs:** In April 2021, a Colorado man was charged with stealing nearly $300,000 in government funds from three different COVID relief programs and with making false statements in connection with bankruptcy proceedings.

  According to court documents, Francis F. Joseph of Highlands Ranch allegedly transferred approximately $118,000 in COVID relief funding from a medical clinic's account into his personal bank account, after which he spent the money on, among other things, travel and home improvements. The stolen funds came from two programs that were designed to aid medical providers during the COVID-19 pandemic—the Accelerated and Advance Payment Program and the Provider Relief Fund.

  The indictment further alleges that following his termination from the clinic, Joseph applied for a $179,999 loan under the Paycheck Protection Program (PPP) on behalf of the medical practice, which he then directed into his personal bank account. Finally, the indictment alleges that Joseph filed for bankruptcy on behalf of (but unbeknownst to) the clinic following his termination and submitted documents containing materially false statements regarding his misappropriation of funds from the clinic in connection with that proceeding.

Joseph is charged with theft in connection with health care, theft of government property, wire fraud, and making a false statement in connection with a bankruptcy proceeding. If convicted, he faces maximum penalties of 10 years in prison for each theft count, 20 years for wire fraud, and 5 years for the bankruptcy proceeding false statement.

This case was investigated by HHS-OIG and the U.S. Small Business Administration-OIG with assistance from the Colorado MFCU, and it was brought in coordination with the Health Care Fraud Unit's COVID-19 Interagency Working Group, which organizes efforts to address illegal activity involving health care programs during the pandemic.

- **Dubuque Care Facility's Owner Agrees to Repay Federal Medicaid Funds to Resolve Allegations Relating to COVID-19 Screening Procedures:** In May 2021, Care Initiatives, a Texas corporation with a home office in West Des Moines, Iowa, agreed to repay the United States $214,200 to resolve claims the United States was entitled to restitution for the Federal share of Medicaid funds the facility received for an approximately 10 week period while residents at Dubuque Specialty Care, a Care Initiatives facility, were suffering from or testing positive for COVID-19.

  The United States alleged that repayment of these funds was warranted due to Dubuque Specialty Care's practices surrounding COVID-19 infections, including the facility's procedures and criteria for screening symptomatic employees.

  Care Initiatives cooperated during the investigation and did not admit to any liability as part of the settlement agreement.

  The case investigated by HHS-OIG.

Durable Medical Equipment

- **Neurosurgeon and Two Affiliated Companies Agree to Pay $4.4 Million to Settle Healthcare Fraud Allegations – Each Defendant Excluded from Federal Healthcare Programs for Six Years:** In May 2021, Neurosurgeon Wilson Asfora, M.D. of Sioux Falls, South Dakota, and two medical device distributorships that he owns, Medical Designs LLC and Sicage LLC, agreed to pay $4.4 million to resolve False Claims Act allegations relating to illegal payments to Asfora to induce the use of certain medical devices, in violation of the Anti-Kickback Statute, as well as claims for medically unnecessary surgeries.

  Medical Designs and Sicage agreed to pay an additional $100,000 in penalties to settle allegations that they violated the Open Payments Program by failing to report to CMS Asfora's ownership interests and payments made to Asfora.

  Under the terms of the settlement agreement, Asfora, Medical Designs, and Sicage each will be excluded from participation in Federal healthcare programs for a period of six years.

  The settlement resolves allegations that over the course of nearly a decade, Asfora, Medical Designs, and Sicage knowingly and willfully engaged in three kickback schemes to allow Asfora to profit from his use of over a dozen devices in his medical procedures.

  First, the United States alleged that Medical Designs and Sicage paid Asfora profit distributions in exchange for Asfora using Medical Designs' and Sicage's devices in his spine surgeries. Second, the United States alleged that Medical Designs acted as a distributor, reselling other manufacturers' spinal devices, and splitting the profits with Asfora when he used those devices in surgeries. Third, the United States alleged that Asfora solicited and received kickbacks from medical device manufacturer Medtronic USA Inc. in exchange for using its SynchroMed II infusion pumps, which are implantable devices used to deliver medication to patients. At Asfora's request,

Medtronic allegedly paid the kickbacks to Asfora through a restaurant he owned with his wife, called Carnaval Brazilian Grill, in the form of lavish meals and alcohol for Asfora and his friends, colleagues, and business partners.

In addition, the settlement resolves allegations that Asfora knowingly submitted false claims to Federal healthcare programs for medically unnecessary procedures using the devices in which he had a financial interest. Despite receiving numerous warnings that he was performing medically unnecessary procedures—including warnings from his own physician colleagues—Asfora allegedly continued to perform such procedures while personally profiting from his use of devices sold by Medical Designs, Sicage, and Medtronic.

The civil settlement includes the resolution of claims that Drs. Carl Dustin Bechtold and Bryan Wellman brought under the qui tam or whistleblower provisions of the False Claims Act against Asfora and Medical Designs. The whistleblowers will receive $880,000 of the settlement proceeds.

The United States has recovered a total of more than $33 million relating to conduct involving Asfora, including a False Claims Act settlement with Sanford Health entities for $20.25 million in October 2019 and a False Claims Act and Open Payments settlement with Medtronic for $9.21 million in October 2020.

This settlement was the result of a coordinated effort between the Civil Division's Commercial Litigation Branch, Fraud Section, and the U.S. Attorney's Office for the District of South Dakota, with assistance from HHS-OIG.

- **French Medical Device Manufacturer to Pay $2 Million to Resolve Alleged Kickbacks to Physicians and Related Medicare Open Payments Program Violations:** In May 2021, Medicrea International, a French medical device manufacturer, and its American affiliate Medicrea USA Inc., agreed to pay:

    - $1 Million to the United States and participating States to resolve civil whistleblower allegations that the companies, by entertaining U.S.-based physicians during a 2013 conference in France, violated the Anti-Kickback Statute and, through resulting claims to federal healthcare programs, the False Claims Act and similar state statutes; and

    - an additional $1 Million to the United States to resolve related allegations that the companies violated the physician Open Payments Program (formerly known as the "Sunshine Act") by failing to fully report those physician-entertainment expenses to CMS.

  The Federal settlement resolves allegations that Medicrea (which Medtronic USA Inc., recently acquired) provided items of value in the form of meals, alcoholic beverages, entertainment, and travel expenses to U.S.-based physicians at events surrounding the Scoliosis Research Society's September 2013 Congress in Lyon, France. The United States alleged that Medicrea provided the benefits to induce the physicians to purchase or order Medicrea's spinal devices, and that this resulted in false payment claims to Federal healthcare programs.

  The settlement also resolves Medicrea's liability under CMS's Open Payments Program. As part of the Affordable Care Act, Congress created the Open Payments Program: (1) to provide greater transparency and protection to consumers by requiring medical device manufacturers and others to publicly disclose certain payments and other transfers of value to physicians; and (2) with the goal of preventing, through such disclosures, payments, and benefits from being used to induce physicians and hospitals to prescribe or buy products. This is among the first settlements to resolve allegations under both the False Claims Act and the Open Payments Program.

The settlement follows the Senate Finance Committee's March 2019 request that HHS-OIG and CMS investigate Open Payments Program non-compliance and pursue enforcement. Manufacturers must ensure accurate and timely Open Payments Program reporting to CMS of all applicable payments or transfers of value, including indirect payments.

The civil settlement includes the resolution of claims brought under the qui tam or whistleblower provisions of the False Claims Act statute.

This case was investigated HHS-OIG, the U.S. Attorney's Office for the Eastern District of Pennsylvania, the Commercial Litigation Branch of the Justice Department's Civil Division, as well as the National Association of Medicaid Fraud Control Units (NAMFCU).

Electronic Health Records

- **Miami-Based CareCloud Health, Inc. Agrees to Pay $3.8 Million to Resolve Allegations That it Paid Illegal Kickbacks:** In April 2021, CareCloud Health, Inc., f/k/a CareCloud Corporation (CareCloud), a Miami-based developer of electronic health records (EHR) software products and related services, agreed to pay over $3.8 million to resolve allegations that it paid unlawful kickbacks to generate sales of its EHR products.

  The United States alleged that CareCloud violated the False Claims Act and the Anti-Kickback Statute through its marketing referral program called the "Champions Program," Specifically, it is alleged that between January 1, 2012 and March 31, 2017, CareCloud offered and provided its existing clients cash equivalent credits, cash bonuses and percentage success payments to recommend CareCloud's EHR products to prospective clients. Existing clients who participated in the Champions Program ("participants") executed written agreements prohibiting them from providing negative information about CareCloud's EHR products to prospective CareCloud clients. Prospective CareCloud clients were not told about this referral-kickback arrangement or about the contract that prohibited participants from sharing negative company information with them.

  The United States alleged that CareCloud's payments to participants violated the Federal Anti-Kickback Statute. In addition, the United States alleged that CareCloud violated the False Claims Act, because the kickback payments rendered false the claims submitted by CareCloud for Federal incentive payments under the Medicare and Medicaid Electronic Health Records Incentive Programs (also known as Meaningful Use Programs) and the Merit-Based Incentive Payment System (also known as MIPS).

  CareCloud was acquired by MTBC, Inc. (MTBC), a public company, in January 2020. CareCloud discontinued the prior version of the marketing referral program that is the basis for this settlement.

  The settlement resolves allegations in a lawsuit filed by Ada De La Vega in Federal court in Miami, Florida. The lawsuit was filed under the qui tam, or whistleblower, provisions of the False Claims Act. The whistleblower share to be awarded in connection with the settlement is $803,270.

  HHS-OIG investigated this matter.

Genetic Testing | Durable Medical Equipment

- **Georgia Woman Admits Participation in Scheme to Obtain Fraudulent Reimbursements for Medical Equipment & Genetic Testing – Conspiracy Was Uncovered in Nationwide Telemedicine Fraud Investigation:** In May 2021, Robin Darnell of Georgia admitted to taking part in a nationwide telemedicine kickback scheme that led to fraudulent Medicare reimbursements for durable medical equipment and genetic testing.

  Robin Darnell, known to some of her co-conspirators as "Nurse Robin," pleaded guilty in an Information charging her with one count of Conspiracy. As described in court documents and testimony, Darnell admitted that from June 2018 through September 2020, she and other conspirators took part in a nationwide telemedicine kickback scheme in which she recruited physicians and other medical professionals to sign orders for durable medical equipment and genetic testing. Darnell claimed to have a team of nurses who would contact patients to conduct exams via telemedicine on behalf of the physicians, in exchange for the health care professionals ordering medical equipment and expensive genetic testing for those patients. In fact, Darnell had no such team of nurses, despite claiming otherwise to the physicians she recruited. Darnell processed thousands of orders, which she knew contained medical histories, conditions, diagnoses, or examinations that Darnell knew were false. Darnell's conspirators then used these orders to bill Medicare for thousands of dollars each. Medicare beneficiaries were located in the Southern District of Georgia and elsewhere.

  The Southern District of Georgia has now charged 33 defendants as part of the nationwide crackdown on fraudulent genetic testing, and prescribing of orthotic braces and pain creams, identifying more than $1.5 billion in losses to Medicare and Medicaid for defendants charged in the Southern District alone.

  The case was investigated by HHS-OIG and the FBI.

Grant Fraud | Those Talents Program

- **University Researcher Sentenced to Prison for Lying on Grant Applications to Develop Scientific Expertise for China (*Case Update*):** In May 2021, Song Guo Zheng, an Ohio man and rheumatology professor and researcher with strong ties to China was sentenced to 37 months in prison for making false statements to Federal authorities as part of an immunology research fraud scheme. As part of his sentence, Zheng was also ordered to pay more than $3.4 million in restitution to the National Institute of Health (NIH) and approximately $413,000 to Ohio State University.

  Zheng was arrested on May 22, 2020, after he arrived in Anchorage, Alaska, aboard a charter flight and as he prepared to board another charter flight in order to flee to China. He was carrying three large bags, one small suitcase and a briefcase containing two laptops, three cell phones, several USB drives, several silver bars, expired Chinese passports for his family, deeds for property in China and other items. He was transported to the Southern District of Ohio and made his first Federal court appearance in Columbus in July 2020.

  Zheng pleaded guilty in November 2020 and admitted he lied on applications in order to use approximately $4.1 million in grants from NIH to develop China's expertise in the areas of rheumatology and immunology.

  According to court documents, Zheng was a professor of internal medicine who led a team conducting autoimmune research at The Ohio State University and Pennsylvania State University. According to his plea, Zheng caused materially false and misleading statements on NIH grant applications, seeking to hide his participation in Chinese Talent Plans and his affiliation and collaboration with a Chinese university controlled by the Chinese government.

According to court documents, since 2013, Zheng had been participating in a Chinese Talent Plan, a program established by the Chinese government to recruit individuals with knowledge or access to foreign technology intellectual property. Since that time, Zheng used research conducted in the United States to benefit the People's Republic of China. Zheng failed to disclose conflicts of interest or his foreign commitments to his American employers or to the NIH.

This case was investigated by HHS-OIG and the FBI.

HIPAA Privacy Violation

- **Former Cedar Rapids Hospital Employee Sentenced for Accessing Ex-Boyfriend's Medical Records – Gave Picture of Medical Record to Friend, Who Uploaded it to Facebook:** In June 2021, a former Cedar Rapids hospital employee, who wrongfully accessed and distributed her ex-boyfriend's medical records, was sentenced on June 14, 2021. Jennifer Lynne Bacor from Las Vegas, Nevada, received probation after pleading guilty to one count of wrongfully obtaining individually identifiable health information under false pretenses.

  In a plea agreement, Bacor admitted she was employed as a patient care technician at a Cedar Rapids hospital. Bacor was authorized to access individually identifiable health information, but only as necessary to provide services to her patients. In 2017, Bacor's ex-boyfriend was repeatedly treated at the same hospital. On multiple occasions between April and October 2017, Bacor used her login credentials to access her ex-boyfriend's protected private health information even though he was not one of her patients. In September 2017, Bacor took a picture of a medical photograph that showed one of her ex-boyfriend's injuries and sent the picture to a third person. The third person then sent the picture to the ex-boyfriend and others on Facebook messenger along with taunting language and emojis.

  Bacor was sentenced in Cedar Rapids by United States District Court Judge C.J. Williams. Bacor was sentenced to 5 years of probation and fined $1,000. During her probationary term, Bacor will be restricted from employment in which she would have access to private medical information of others. In sentencing Bacor, Judge Williams observed that Bacor had "weaponized" her ex-boyfriend's private medical information.

  This case was investigated by HHS-OIG.

Hospice | Home Health

- **Sacramento Area Home Health Care and Hospice Agencies Owner Pleads Guilty to Conspiring to Defraud Medicare:** In April 2021, Liana Karapetyan, of El Dorado Hills, California, pleaded guilty to one count of conspiracy to commit health care fraud and one count of conspiracy to pay and receive health care kickbacks.

  According to court documents, Karapetyan and another individual owned and controlled home health care and hospice agencies in the greater Sacramento area: ANG Health Care Inc., Excel Home Healthcare Inc., and Excel Hospice Inc. On behalf of the agencies, Karapetyan and another individual certified to Medicare that they would not pay kickbacks in exchange for Medicare beneficiary referrals to the agencies.

  Despite their certifications, from at least July 2015 through April 2019, Karapetyan and another individual paid and directed others to pay kickbacks to multiple individuals for beneficiary referrals, including employees of health care facilities, as well as employees' spouses. The kickback recipients included John Eby, a registered nurse who worked for a hospital in Sacramento; Anita Vijay, the director of social services at a skilled nursing and assisted living facility in Sacramento; Jai Vijay, Anita Vijay's husband; and Mariela Panganiban, the director of social services at a skilled nursing facility in Roseville, California.

In total, Karapetyan and others caused the agencies to submit over 8,000 claims to Medicare for the cost of home health care and hospice services. Based on those claims, Medicare paid the agencies approximately $31 million. Of that amount, Medicare paid the agencies at least over $2 million for services purportedly provided to beneficiaries referred in exchange for kickbacks paid to, among others, Eby, Anita Vijay, Jai Vijay, and Panganiban. Because the agencies obtained the beneficiary referrals by paying kickbacks, the agencies should not have received any Medicare reimbursement.

Karapetyan faces maximum statutory penalties of 10 years in prison for the health care fraud conspiracy charge and 5 years in prison for the kickback conspiracy charge. She also faces a maximum fine of $250,000.

This case was investigated by HHS-OIG and the FBI.

Home Health

- **Home Health Company Pays $28K for Employing "Excluded" Individual:** In April 2021, CareCo Medical, Inc. (CareCo), and its owner and CEO, Helga Pfanner, entered into a civil settlement agreement with the Federal Government in which they will pay $28,246 to resolve allegations that they improperly employed an individual who was excluded from all Federal healthcare programs. CareCo is a Waterford-based home healthcare organization that provides skilled nursing services, medical social worker services, and rehabilitative therapies.

  As background, in May 2013, HHS-OIG issued an Updated Special Advisory Bulletin containing additional guidance regarding excluded individuals. Both the original and updated Special Advisory Bulletins advised that, in order to avoid potential liability, health care providers should check the List of Excluded Individuals/Entities on the HHS-OIG web site.

  In 2012, Todd Roberts, a physical therapist, pleaded guilty to one count of obstructing a Federal audit and, pursuant to a related civil settlement agreement, agreed to pay $328,828. In addition, Roberts entered into a 6-year Integrity Agreement HHS-OIG designed to ensure future compliance with the requirements of the Medicare program. Roberts later defaulted on his obligations under the Integrity Agreement and was excluded from all Federal health care programs in 2015.

  In November 2018, CareCo and Pfanner hired Roberts for a management position at CareCo. Roberts served in that position until March 2019.

  To resolve their liability for hiring and employing Roberts while he was excluded from all Federal healthcare programs, CareCo and Pfanner will pay $28,246.

  This matter was investigated by HHS-OIG.

- **Texas Woman Handed Significant Sentence for Health Care Fraud Scheme:** In May 2021, Brenda Rodriguez of Richmond, Texas, was ordered to Federal prison for 25 years, to be followed by 3 years of supervised release, subsequent to her convictions of conspiracy, and aiding and abetting health care fraud. At the hearing, the court heard evidence of Rodriguez's role in a larger conspiracy where she was responsible for all of the loss to taxpayers the scheme generated.

  By way of background, Rodriguez owned and operated the QC Medical Clinic in Richmond. At trial, the jury heard that Rodriguez paid doctors to approve patients for home health care regardless of whether it was medically necessary. Rodriguez then sold those approvals to various corrupt home health care providers. These providers then billed Medicare for services that were either unnecessary or never provided.

During the trial, jurors were able to watch video that captured the fraud committed at Rodriguez's clinic. Potential clients were given brief exams, often by unlicensed people posing as doctors, and then quickly approved for medical services that were unnecessary.

As a result of the investigation and prosecution, several other doctors and administrators have also been convicted of crimes ranging from Medicare fraud to the payment of kickbacks.

Ultimately, the providers billed Medicare for over $11 million as a result of patients Rodriguez provided.

HHS-OIG and the FBI investigated this matter, and it was brought as part of the Medicare Fraud Strike Force.

- **Final Defendant Sentenced in $80 Million Home Health Care Fraud Conspiracy:** In May 2021, Alberto Orian Gonzalez-Delgado of Miami, Florida, was sentenced to 210 months in prison for conspiracy to commit health care fraud and wire fraud. In March 2021, Gonzalez-Delgado pleaded guilty to both counts. Gonzalez-Delgado is the last remaining defendant in a group of seven other co-conspirators to be sentenced.

  According to court documents, these eight individuals and their co-conspirators operated a fraud and money laundering organization responsible for executing a series of frauds in Florida and Michigan through which they billed Medicare for over $80 million, actually receiving approximately $53 million for fraudulent claims.

  The organization recruited and directed nominee owners to fraudulently purchase home health agencies, as well as to open sham corporations in their names, along with corresponding personal and corporate bank accounts. After the acquisition of the home health agency was completed, the group began fraudulently billing Medicare for services that were never provided. The home health agencies had no medical staff and provided no services to any beneficiaries. The group, upon receiving the Medicare money, would funnel that through several layers of shell companies and bank accounts in an effort to launder the money before converting it to cash at ATMs and check cashing stores in Miami. Once the nominee owners completed their work, the group required them to permanently move to Cuba to avoid detection and live beyond the jurisdiction of the United States.

  The FBI and HHS-OIG investigated the case, with assistance from the CMS Center for Program Integrity.

Laboratory Fraud

- **Louisiana Doctor Sentenced to Prison for Conspiring to Receive Health Care Kickbacks:** In April 2021, Louisiana doctor Gray Wesley Barrow, M.D., a was sentenced to 18 months in prison for his role in a scheme to receive approximately $336,000 in illegal health care kickback payments.

  In November 2018, Barrow pleaded guilty to one count of conspiracy to pay and receive health care kickbacks. According to court documents, Barrow was a co-owner of Louisiana Spine & Sports LLC, a pain management clinic located in Baton Rouge. Barrow agreed to send urine specimens collected from his patients to a drug testing laboratory in return for an unlawful kickback calculated as a percentage of the reimbursements paid to the laboratory by Medicare and other health care benefit programs.

From approximately January 2014 through July 2016, Barrow sent specimens collected from his patients to the laboratory and received approximately $1.58 million in disbursements from the laboratory. Of that $1.58 million, approximately $336,000 represented kickback payments associated with testing performed on specimens of Medicare beneficiaries, which the court ordered Barrow to forfeit as part of his sentence. Additionally, Barrow was ordered to pay $336,000 in restitution.

HHS-OIG and the FBI investigated the case.

- **U.S. Recovers $650,000 from Local Providers Who Billed Medicare and Medicaid for Screening Tests Not Performed:** In June 2021, the United States reached a settlement that resolved civil claims against Zaheer Shah, M.D., Park Square Urgent Care, Inc., and several affiliated entities, related to the defendants' alleged submission of false claims to Medicare and Medicaid for urine drug screening tests they were ill-equipped to perform.

  The agreement, under which the defendants will pay a total of $650,000, resolves a civil case filed by the Government in Federal court in the District of Rhode Island. The settlement is based on an analysis of the defendants' ability to pay based on an extensive review of their current financial condition.

  The Government's case alleged that these medical providers, acting under the direction of Dr. Shah, submitted tens of thousands of false claims to Medicare and Medicaid, seeking reimbursement for urine drug tests that they did not, and could not, perform, because their testing laboratories lacked the equipment or capability to carry out the tests. Despite the fact that these labs could only perform simpler tests, which carry a lower reimbursement rate, the labs were alleged to have knowingly billed Medicare and Medicaid for more complex, and expensive, drug screening tests.

  This case was investigated by HHS-OIG.

- **Owner Of Spring Hill-Based Crestar Labs, LLC, Charged In Massive Medicare Fraud Scheme – Allegations Include $86 Million Fraudulently Billed to Medicare:** In early July 2021, the owner and Chief Executive Officer (CEO) of Spring Hill, Tennessee-based Crestar Labs, LLC, (Crestar) was charged with aiding and abetting and violation of the anti-kickback statute for his role in orchestrating a fraudulent Medicare billing scheme relating to genetic testing in cancer patients.

  The criminal complaint alleges that beginning as early as 2016, Alshalabi, as the owner of Crestar, engaged in a scheme to pay illegal health care kickbacks in exchange for the solicitation of genetic tests from Medicare beneficiaries. In addition to the laboratory in Spring Hill, Alshalabi owned associated labs in other locations, including Karemore Labs in Baltimore, Maryland, and Martis Labs and CrestarDX in Dallas, Texas.

  Alshalabi, as the owner and CEO, contracted with marketing companies to target and recruit elderly patients who were Federal health care program beneficiaries in order to obtain their genetic material for conducting genetic tests. Marketers, who were not health care professionals, obtained swabs from the mouths of the patients at nursing homes, senior health fairs, and elsewhere. The tests were then approved by telemedicine doctors who did not engage in the treatment of the patients, and often did not even speak with the patients for whom they ordered tests. Often, the patients or their treating physicians never received the results of the tests. Alshalabi paid illegal kickbacks and bribes in exchange for the doctor's orders and tests, without regard to any medical necessity. During the period of late 2017 to present, Crestar billed Medicare approximately $86 million for genetic testing and was paid almost $14 million for those claims. If convicted, Alshlabi faces up to 10 years in prison.

  This case is being investigated HHS-OIG and the FBI.

Medicaid

- **Bristol-Myers Squibb to Pay $75 Million to Resolve False Claims Act Allegations of Underpayment of Drug Rebates Owed Through Medicaid:** In April 2021, Bristol-Myers Squibb (BMS) agreed to pay the United States and participating States a total of $75 Million, plus interest, to resolve allegations that it knowingly underpaid rebates owed under the Medicaid Drug Rebate Program. Of that amount, BMS will pay approximately $41 million, plus interest, to the United States, and the remainder to States participating in the settlement.

  Pursuant to the Medicaid Drug Rebate Program (MDRP), drug manufacturers are required to pay quarterly rebates to State Medicaid programs in exchange for Medicaid's coverage of the manufacturers' drugs. The quarterly rebates are based, in part, on the Average Manufacturer Prices (AMPs) that the manufacturers report to the government for each of their covered drugs. Generally, the higher the reported AMP for a drug, the greater the rebate the manufacturer pays to State Medicaid programs for the drug.

  This settlement resolves allegations that BMS underreported AMPs for a number of its drugs by improperly reducing the reported AMPs for service fees paid to wholesalers, and by improperly excluding from the reported AMPs additional value it received pursuant to price appreciation provisions in its contracts with wholesalers. As a result, BMS allegedly underpaid quarterly rebates owed to the states and caused the United States to be overcharged for its payments to the states for the Medicaid program.

  This settlement resolves a lawsuit filed by Ronald J. Streck under the whistleblower provisions of the False Claims Act. The government declined intervention of this matter, and the relator and his counsel proceeded with the case.

  The settlement was a coordinated effort among the DOJ Civil Division's Commercial Litigation Branch, the United States Attorney's Office for the Eastern District of Pennsylvania, and the National Association of Medicaid Fraud Control Units.

- **New York Dental Clinics Agree to Pay $2.7 Million for Alleged Use of Unsterilized Tools – New York Attorney General Teams With Federal Prosecutors to Make Dental Clinics Agree to Pay $2.7 Million for Alleged Use of Unsterilized Tools:** In May 2021, the New York Attorney General, and the United States Attorney's Office in the Western District of New York and Pennsylvania, reached an agreement with a health care system operating several clinics in the Southern Tier of New York and Pennsylvania for allegedly treating patients with unsterilized and potentially dangerous tools.

  An agreement with the Upper Allegheny Health System (UAHS)—a domestic not-for-profit corporation that operates several dental clinics in the Southern Tier—resolved claims made by a former employee alleging that UAHS billed Medicaid for dental services where it failed to sterilize dental handpieces between patients. As part of the agreement, UAHS agreed to pay $2.7 million to the United States, New York, and Pennsylvania — $2.4 million of which will, specifically, resolve claims pertaining to New York's Medicaid program ($1.4 million will go to New York and $1 million will go to the Federal government).

  Between April 1, 2010 and May 31, 2015, UAHS allegedly conducted dental services with dental handpieces that had not been heat sterilized between patient use and subsequently billed Medicaid for these services. Not only did the use of these unsterilized tools pose a health hazard to patients, but the billing of these services to Medicaid was a violation of both New York State and Federal laws. The CDC, the American Dental Association, and the manufacturer of the dental tools require that dental handpieces be heat sterilized between patient use.

The investigation commenced after a whistleblower complaint was filed by a former UAHS employee under the qui tam provisions of the New York False Claims Act as well as the Federal False Claims Act. The agreement forced UAHS to pay a total of $2.7 million in damages to the United States, New York, and Pennsylvania.

This matter was investigated by the New York and Pennsylvania MFCUs.

- **Plant City Resident Arrested for Stealing More Than $180,000 from Taxpayer-Funded Program:** In June 2021, Ratonia Thompson was arrested for stealing more than $180,000 from the Medicaid program. Over the course of 4 years, Thompson allegedly stole from the tax-payer-funded program, instead of distributing the funds to caregivers.

  Attorney General Ashley Moody said, “The scheme concocted by this con artist not only exploited a disabled Floridian and the Florida Medicaid program, it also put the financial well-being and good standing with the IRS of other caregivers in jeopardy.”

  According to a joint investigation the Florida MFCU and HHS-OIG, a disabled adult placed in Ratonia Thompson’s care and custody was enrolled as a Medicaid recipient in the Consumer Directed Care+ program. CDC+ is jointly funded by the Federal government and the Florida Medicaid program, and it allows disabled recipients and family members to personally direct the recipient’s care.

  Ratonia Thompson registered with CDC+ as the disabled adult’s representative—an unpaid position that empowered Thompson to hire employees to aid with the adult’s activities of daily living, such as bathing, cleaning, and feeding. Instead, Ratonia Thompson routinely submitted falsified service logs claiming the services rendered and pocketed the Medicaid payments intended for caregivers through debit cards registered in the names of caregivers who previously provided services, but no longer worked for the disabled adult.

  The investigation began after the Agency for Persons with Disabilities received a complaint from a former caregiver citing timesheets fraudulently submitted in the caregiver’s name. Upon review, it was found that Gregory Thompson, Ratonia Thompson’s husband, became the representative for the disabled adult and was responsible for submitting caregiver timesheets for payment. However, APD found that Gregory Thompson had died, but timesheets continued to be submitted by someone claiming to be him. Further investigation found that the caregivers reported on the timesheets no longer worked for the disabled adult, and the former caregivers did not receive payment for the services claimed. The investigation found that instead of the intended payments going to the former caregivers, Ratonia Thompson spent the funds on the debit cards for personal expenses.

  Additionally, a former caregiver for the disabled adult received notice of an audit after the Internal Revenue Service discovered more than $23,000 not reported in tax filings. The caregiver never made that amount of money while working for the disabled adult and realized Ratonia Thompson illegally submitted timesheets claiming the services rendered and subsequently pocketed the money. According to the MFCU investigation, from December 2017 through March 2021, Ratonia Thompson illegally collected more than $180,000 from the Medicaid program.

  Ratonia Thompson is charged with one count of Medicaid fraud more than $50,000, and one count of organized fraud more than $50,000; both are first-degree felonies. If convicted, Thompson faces up to 60 years in prison and $20,000 in fines.

  This case was investigated by the Florida MFCU, HHS-OIG, and the Florida Agency for Persons with Disabilities.

Medical Identity Theft | Medicaid

- **President and Vice President of Mental Health and Substance Abuse Treatment Programs Plead Guilty to Medicaid Fraud and Medical Identity Theft:** In June 2021, Tasha S. Saunders and Diane S. Jordan of Parkville, Maryland, each pleaded guilty to one count of felony Medicaid Fraud for submitting claims that caused the Maryland Medical Assistance Program (Medicaid) to reimburse their companies, Changing Directions, Inc. and HEAL Inc., more than $470,000 for services that were not provided using the stolen identities of Medicaid providers and recipients.

  Saunders was sentenced to 5 years of incarceration, all but 9 months of jail suspended and 9 months of home detention. Saunders was also ordered to 3 years of supervised probation and directed to pay restitution to Medicaid in the amount of $470,745.

  Jordan was sentenced to 5 years of incarceration, all suspended but 1 year of home detention. Jordan was also placed on 3 years of supervised probation and ordered to pay restitution to Medicaid in the amount of $470,745.

  Saunders was the founder and president of a mental health and substance abuse treatment program operating in Baltimore City. Jordan was the vice president of the companies. From as early as July 2016 to May 2019, Saunders and Jordan submitted at least 3,909 claims for reimbursement. Many of the Medicaid recipients whose information was used for billing were not clients of the programs and never received services. In addition, Saunders and Jordan used the stolen identities of licensed counselors for billing claims and creating fictitious patient files to support the fraudulent billing.

  This case was investigated by the Maryland MFCU and the Maryland Department of Health-OIG.

- **Jury Convicts South Dakota Woman of Health Care Fraud and Identity Theft:** In May 2021, Holli Telford Lundahl of Oelrichs, South Dakota, was convicted by a jury on charges of three counts of health care fraud and two counts of aggravated identity theft after a one-week trial in the United States District Court for the District of Wyoming.

  In March 2020, Holli Lundahl was indicted on the charges which included three overlapping schemes to defraud Wyoming Medicaid by submitting false claims for long-term care provided to Lundahl's sibling, and the unlawful possession and use of identity information of two individuals in furtherance of two of the charged schemes.

  The evidence at trial showed that Wyoming Medicaid operates a long-term care program designed to keep beneficiaries out of nursing homes and other institutional settings. This program includes limited payments for certain direct support services provided to beneficiaries by properly qualified and enrolled workers. Lundahl enrolled her niece in this program as a caregiver for Lundahl's sister using the niece's name, social security number, and other identifying information. Lundahl then submitted claims to Wyoming Medicaid for direct support work using the niece's name when the niece had not provided any services. Lundahl's niece did not know her identity was being used and had never been to Wyoming before testifying at trial. The false information provided by Lundahl caused Wyoming Medicaid money to be paid in the niece's name into a credit union account controlled by Lundahl.

  Evidence at trial also proved that Lundahl advertised for a direct support worker in Lusk. When a young woman responded to the ad, Lundahl convinced the woman to give her social security number and other identification information to Lundahl to be hired for the job. The woman worked 1 day, was paid cash for her time, and was not asked to return. The young woman did not know that she was enrolled with Medicaid or that her information was used for that purpose. However, Lundahl then used the young woman's information to submit false claims to Wyoming Medicaid for direct support work that the woman did not perform. The false information provided by Lundahl

caused Wyoming Medicaid money to be paid in the young woman's name into a credit union account controlled by Lundahl.

Finally, evidence at trial proved that Lundahl enrolled herself as a direct support worker when she had a power of attorney for her sister and therefore could not be enrolled under Medicaid's long-term care rules. Lundahl then submitted claims to Wyoming Medicaid for direct support work when she was not eligible to be paid for this work. As a result, Wyoming Medicaid money was paid to Lundahl when she was not eligible to receive that money.

Lundahl may be sentenced up to 10 years in prison for each health care fraud count and must be sentenced to a mandatory 2-year prison term for each identity theft count. The 2-year identity theft prison sentences must be consecutive to any prison term imposed for the health care fraud counts, but may be imposed concurrent to one another. A fine of up to $250,000 could be imposed for each count.

The case was investigated by the Wyoming MFCU and prosecuted by the Wyoming Attorney General's Office and Assistant United States Attorney.

Medicare Part A | Hospital

- **Neurosurgical Associates, LTD and Dignity Health, d/b/a St. Joseph's Hospital, Paid $10 Million to Resolve False Claims Allegations:** In May 2021, Neurosurgical Associates, LTD and Dignity Health, d/b/a St. Joseph's Hospital, paid $10 million to resolve civil allegations that they violated the Federal False Claims Act (FCA).

  Dignity Health is one of the largest healthcare systems in the United States and does business under the names of hospitals that it owns and operates, including St. Joseph's Hospital in Phoenix, Arizona. Neurosurgical Associates, LTD is an Arizona corporation, located on the campus of St. Joseph's Hospital.

  The December 2020 settlement resolves allegations that St. Joseph's Hospital and Neurosurgical Associates, LTD billed Medicare for certain doubly and triply concurrent and overlapping surgeries, in violation of applicable regulations and reimbursement policies.

  The settlement resolves a lawsuit filed in June 2018 by Dr. Bruce P. Kingsley under the qui tam, or whistleblower, provisions of the False Claims Act, which allow private citizens to bring civil actions on behalf of the United States and share in any recovery obtained.

  Contemporaneous with a settlement of the FCA claims in this matter, Neurosurgical Associates, LTD entered into a corporate integrity agreement (CIA) with the Department of Health and Human Services Office of Inspector General (HHS-OIG). The five-year CIA addresses the conduct at issue and requires, among other things, that Neurological Associates, LTD maintain a compliance program, implement a risk assessment program, and hire an Independent Review Organization to annually review Neurosurgical Associates' Medicare and Medicaid claims.

  The settlement is neither an admission of liability by Neurosurgical Associates, LTD, or St. Joseph's Hospital, nor is it a concession by the United States that its claims are not well founded.

  The case was investigated by HHS-OIG.

Medicare Part B

- **South Carolina's Largest Urgent Care Provider and its Management Company to Pay $22.5 Million to Settle False Claims Act Allegations:** In April 2021, Doctors Care, P.A. (Doctors Care)—South Carolina's largest urgent care provider network—and its management company, UCI Medical Affiliates of South Carolina, Inc. (UCI), agreed to pay $22.5 million to resolve civil allegations of healthcare fraud in violation of the False Claims Act.

  The case began with a whistleblower complaint alleging that Doctors Care, UCI, and UCI Medical Affiliates, Inc. (a related holding company), falsely certified that certain urgent care visits were performed by providers who were credentialed to bill Medicaid, Medicare, and TRICARE for medical services. According to the complaint, the services were performed by non-credentialed providers.

  As early as 2013 and continuing to 2018, it is alleged that UCI was unable to secure and maintain necessary billing credentials for most Doctors Care providers. UCI knew that Federal insurance programs would deny claims submitted with the billing number of a provider who had not yet received their billing credentials. But instead of solving its credentialing problem—or holding claims while a temporary solution could be found—UCI allegedly submitted the claims falsely, "linking" the uncredentialed rendering providers to credentialed billing providers in order to get the claims paid.

  With each "linked" bill, it is alleged that UCI knowingly submitted a false claim for payment. Evidence obtained in support of the allegations includes emails memorializing UCI's "linking" scheme and well-organized "cheat sheets," as employees called them, which UCI used to keep track of properly credentialed billing providers whose names could be substituted on uncredentialed providers' bills.

  The "billing credentials" at issue in this case are distinct from a provider's degree or license to practice medicine. There is no evidence in this case that any Doctors Care provider lacked a medical license or that patient care was compromised due to the conduct at issue.

  The settlement of $22.5 million is the result of a more than 3-year investigation, led by the United States Attorney's Office in coordination with the HHS-OIG and DCIS.

  In addition to the monetary settlement, UCI and Doctors Care also entered into a Corporate Integrity Agreement with HHS-OIG. Among other things, the Corporate Integrity Agreement (CIA) requires that for the next 5 years UCI must retain an Independent Review Organization to perform a claims review in accordance with the specific requirements of the CIA, and it requires that UCI routinely be monitored by HHS-OIG.

- **Surgical Care Affiliates and Orlando Surgery Center Agree to Pay $3.4 Million to Settle False Claims Act Liability:** In June 2021, Surgical Care Affiliates, LLC, and Orlando Center for Outpatient Surgery, LP, agreed to pay the United States $3.4 million to resolve allegations that both companies violated the False Claims Act by submitting claims for kidney stone procedures that were not medically justified and for engaging in an illegal kickback arrangement.

  The United States previously intervened in a whistleblower lawsuit against SCA and the Orlando Center on October 15, 2019. The lawsuit and settlement concern the submission of claims for extracorporeal shock wave lithotripsy, a procedure used to break up kidney stones. According to the lawsuit, Dr. Patrick Hunter was a urologist who performed lithotripsy procedures at the Orlando Center, a facility affiliated with SCA. According to the settlement agreement, between January 2010 and April of 2016, the Orlando Center submitted claims for lithotripsy procedures performed on Medicare and TRICARE patients by Dr. Hunter that were medically unnecessary because the procedures were not medically indicated or because the patients did not have kidney stones.

The settlement agreement also resolves allegations that Dr. Hunter, SCA, and the Orlando Center engaged in an illegal kickback arrangement, where Dr. Hunter performed the lithotripsy procedures in exchange for per-procedure payments from the Orlando Center. Dr. Hunter allegedly agreed to perform his lithotripsy procedures at the Orlando Center in exchange for payments from the Orlando Center, in violation of the Anti-Kickback Statute. SCA vetted and approved the agreement. These procedures were then billed to and paid by Medicare and TRICARE in violation of the False Claims Act.

The settlement resulted from a False Claims Act lawsuit brought by Scott Thompson. Mr. Thompson sued under the qui tam, or whistleblower, provisions of the False Claims Act. The United States intervened in this matter and litigated the case. Mr. Thompson will receive $748,000 of the proceeds from the settlement with SCA and the Orlando Center.

Dr. Hunter passed away in March 2019. In November 2020, Dr. Hunter's estate paid the United States $1.75 million to resolve the government's claims arising from Dr. Hunter's alleged participation in the scheme.

This settlement resulted from a coordinated effort by the U.S. Attorney's Office for the Middle District of Florida, HHS-OIG, and the Defense Health Agency.

Medicare Part B | Medical Identity Theft

- **Cardiologist Sentenced To Prison For Decade-Long Health Care Fraud Scheme – Asim Hameedi Provided False Patient Medical Information and Used Identities of Doctors Who Did Not Work at the Clinic to Submit Fraudulent Health Care Claims:** In May 2021, cardiologist Asim Hameedi was sentenced to 20 months in prison for orchestrating a widespread healthcare fraud scheme from approximately 2003 to 2015. Hameedi owned a Queens, New York, medical clinic, City Medical Associates (CMA), through which he perpetrated a fraud scheme involving, among other things, fraudulent reimbursement claims and false representations to insurers regarding medical tests and procedures.

  According to the Indictment, other court filings, and statements made in public court proceedings:

  - CMA, a cardiology and neurology clinic based in Bayside, Queens, conducted a multifaceted scheme spanning approximately 12 years and involving millions of dollars in falsified claims. Hameedi, a board-certified interventional cardiologist, was CMA's president and owner. As Hameedi has acknowledged, he was a leader of this long-running, wide-ranging fraud scheme, which involved various co-conspirators and several codefendants.

  - Hameedi's healthcare fraud scheme included, among other things: (1) making false representations to insurance providers about patients' symptoms in order to obtain preauthorization for medical tests and procedures; (2) backdating bills in order to create the false impression that medical procedures had not been performed until after CMA received "pre"-authorization from an insurer; (3) submitting false claims to insurance providers for parts of tests that were not performed, as well as for drug items not used or provided; (4) evading scrutiny from insurers for the large volume of claims that CMA submitted by falsely representing that several doctors—who did not work at CMA—had purportedly ordered or performed tests or procedures there; and (5) violating HIPAA by accessing, without authorization, electronic health records of patients at a particular hospital on Long Island, New York, in order to identify patients to be recruited to CMA. Additionally, Hameedi tried to obstruct an investigation by hospital officials into misconduct by his nephew, codefendant Fawad Hameedi.

In addition to his prison sentence, Hameedi was sentenced to 2 years of supervised release, restitution of $554,331, and a $100,000 fine.

HHS-OIG, the FBI, and the New York City Police Department investigated this matter. The USAO's Southern Complex Frauds and Cybercrime Unit is handling the criminal case.

Mental | Behavioral Health

- **Final Four Sentenced in $189M Health Care Fraud Scam (*Case Update*):** In April 2021, four executives of Continuum Healthcare and its various health centers were ordered to Federal prison for a massive scam perpetrated in the Houston area. Bobby Rouse and Steven Houseworth both of Houston, Texas; Jeffery Parsons Crockett; and David Edson of Palm Harbor, Florida, all pleaded guilty to their respective roles in the scam.

  On April 22, 2021, Rouse was sentenced to 120 months in prison. Edson received a 48-month term of imprisonment, while Parsons and Houseworth each received 30 months in prison.

  Rouse, Houseworth, Edson and Parsons were part of the executive team for Continuum Healthcare LLC, which owned Westbury Community Hospital in Houston as well as community mental health centers in the Houston area known by their locations as Hornwood, Baytown and Missouri City.

  Each location operated a partial hospitalization program (PHP). The PHP was supposed to be a treatment program for individuals with mental illness, intended to closely resemble a highly structured, short-term hospital inpatient program. However, while it was a distinct and organized intensive treatment program, it offered less than 24-hour daily care.

  In 2010, Continuum opened Westbury Community Hospital with Hornwood and Baytown becoming outpatient centers and continuing to operate their existing PHPs under the Westbury name. Westbury also opened a PHP.

  The four men were responsible for the day-to-day operation of Continuum/Westbury and were involved in the implementation of the various kickback programs. Numerous people were referred for treatment in exchange for payment. However, the vast majority did not qualify for PHP services, because they were not experiencing an acute psychotic episode or were actually suffering from mental retardation, dementia, or Alzheimer's.

  In total, Continuum billed Medicare approximately $189 million in total for fraudulent PHP services and Medicaid paid approximately $66 million on those clams.

  This case was investigated by HHS-OIG, the FBI, the Texas MFCU, and the IRS.

Nursing Home

- **California's Second-Largest Skilled Nursing Facility Operator Paid $450,000 to Resolve False Claims Act Allegations:** In June 2021, Skilled nursing facility operator Plum Healthcare Group LLC and its entity Azalea Holdings LLC, dba McKinley Park Care Center agreed to pay more than $451,439 to resolve allegations that they violated the False Claims Act.

  Specifically, Plum Healthcare Group agreed to resolve allegations that an employee at its McKinley Park Care Center knowingly created billing records for services that were not actually provided. According to the settlement agreement, Plum Healthcare Group then used these false records to bill Medicare, leading it to obtain Medicare reimbursements that were higher than warranted. The government also alleges that the management of Plum Healthcare Group learned of the extent of these false billings to Medicare, did not conduct an adequate investigation into

this conduct, and then failed to submit a refund to Medicare for the full amount management knew had been overbilled or otherwise disclose its false billings to the government.

The settlement with Plum Healthcare Group resolves allegations originally brought in a lawsuit filed by a former employee under the whistleblower provisions of the False Claims Act. The whistleblower will receive over $90,000 as her share of the recovery from Plum Healthcare Group.

This case was the result of an investigation by HHS-OIG and the FBI.

- **United States Files Suit Against California Skilled Nursing Chain and its Owner for Allegedly Paying Illegal Kickbacks to Physicians:** In June 2021, the United States filed a lawsuit under the False Claims Act against Paksn Inc.; Prema Thekkek, one of its owners; and seven skilled nursing facilities (SNFs) owned by Thekkek and/or operated by Paksn. The seven SNFs are Bay Point Healthcare Center, Gateway Care & Rehabilitation Center, Hayward Convalescent Hospital, Hilltop Care & Rehabilitation Center, Martinez Convalescent Hospital, Park Central Care & Rehabilitation Hospital, and Yuba Skilled Nursing Center.

  The United States alleges that defendants entered into medical directorship agreements with certain physicians that purported to provide compensation for administrative services, but in reality, were vehicles for the payment of kickbacks to induce the physicians to refer patients to the seven SNFs.

  Specifically, the United States alleges that defendants hired certain physicians who promised in advance to refer a large number of patients to the SNFs, paid physicians in proportion to the number of expected referrals, and terminated physicians who did not refer enough patients. On one occasion, a Paksn employee told Thekkek that two physicians were being hired because "they are promising at least 10 patients for $2,000 per month." On another, Thekkek complained that if Paksn's employees did not pay medical directors promptly every month, "[t]hese doctors will not give us patients." On a third occasion, a Paksn employee told Thekkek that because "lately there are no real referrals" from one of the medical directors, "I am planning to say goodbye to him."

  The lawsuit was initially filed in December 2015 by Trilochan Singh, who was previously employed as Paksn's Vice President of Operations and Chief Operating Officer, under the whistleblower provisions of the False Claims Act.

  This matter was investigated by HHS-OIG and handled by the Civil Division's Commercial Litigation Branch (Fraud Section), and the U.S. Attorney's Office for the Central District of California.

Pain Management

- **Comprehensive Pain Specialists and Former Owners Agree to Pay Over $4.1 Million to Settle Fraud Allegations:** In April 2021, the United States Government entered into agreements with Anesthesia Services Associates, PLLC (dba Comprehensive Pain Specialists (CPS)), its four majority owners—Dr. Peter B. Kroll, Dr. Steven R. Dickerson, Dr. Gilberto A. Carrero, and Dr. Richard J. Muench (collectively, the Owners)—and Russell S. Smith, D.C., a former CPS executive. Collectively, the aforementioned parties agreed to pay over $4.1 million to settle all claims by the United States and Tennessee involving allegations of wrongdoing at CPS.

  CPS, which was based in Brentwood, Tennessee, at one point operated over 40 pain clinics and had operations in 12 States, until it shut down in 2018. In April 2019, former CPS CEO, John Davis, was convicted of health care fraud, as well as three of the four principal Owners—Drs. Kroll, Dickerson, and Carrero, and, Dr. Smith, a former manager of certain CPS clinics in East Tennessee—on allegations that they, among other things, submitted false claims for medically

unnecessary and/or non-reimbursable testing and acupuncture. Dr. Muench, the only owner not a party to the lawsuit, agreed to settle with the United States and Tennessee prior to the filing of the Complaint.

The agreements with CPS and the Owners resolve allegations that arose from the sub-mission of false claims to Federal health care programs and TennCare, specifically for medically unnecessary and/or non-reimbursable urine drug, specimen validity, genetic and psychological testing, as well as claims for auricular electro-acupuncture during the period from May 2011 through when CPS ceased operating in 2018. The settlement also resolves claims relating to CPS's submission of false claims under Dr. Kroll's provider number for services he did not render and testing he did not order.

To resolve the Civil Action, CPS agreed to release approximately $2.2 million in funds held by Medicare in a suspension account and will contribute an additional $750,000 in cash. The Owners will pay a total of $1.05 million to resolve claims against them. Dr. Smith also agreed to pay $125,000 to resolve potential liability for common law claims that could be brought against him by the United States and Tennessee. As part of the settlements, the United States and Tennessee agreed to dismiss the Civil Action, except for their claims against John Davis.

The allegations resolved by this settlement were originally raised in lawsuits filed under the qui tam, or whistleblower, provisions of the False Claims Act. The whistleblowers will receive $610,685 as their share of the Governments' settlement proceeds from the CPS settlement and will dismiss their individual actions.

The case was investigated by HHS-OIG and the Tennessee Bureau of Investigation MFCU.

- **Associate Medical Director of Baltimore County Pain Management Practice Pleads Guilty to Accepting Kickbacks: (*Case Update*):** In June 2021, Howard Hoffberg, M.D., of Reisterstown, Maryland, pleaded guilty on June 9, 2021, to the Federal charge of conspiracy to violate the anti-kickback statutes, in connection with a scheme to accept payments from a pharmaceutical company in exchange for prescribing a drug the company marketed for breakthrough pain in cancer patients for off-label purposes.

  According to his guilty plea, Howard Hoffberg, is a doctor and was licensed to practice medicine in the State of Maryland. He served as the Associate Medical Director and part owner of Rosen-Hoffberg Rehabilitation and Pain Management (the Practice). The Practice's Medical Director was Norman Rosen, who worked primarily at the Practice's Towson, Maryland locations. Hoffberg principally worked at the Practice's location in Owings Mills, Maryland, but at times also was at the Practice's locations in Towson, Maryland.

  In September 2011, Hoffberg certified to Medicare that he would comply with Medicare rules and regulations, including that he would refrain from violating the Federal anti-kickback statute. Moreover, in August 2013, Hoffberg certified to the FDA, as part of his ability to prescribe drugs known as Transmucosal Immediate Release Fentanyl (TIRF) drugs, that: (a) he understood TIRF drugs are indicated only for the management of breakthrough pain in cancer patients; (b) he understood that TIRF drugs can be abused by patients; and (c) he understood that one TIRF drug is not interchangeable with another TIRF drug.

  As detailed in his plea agreement, starting in June 2012, Hoffberg solicited and received kickbacks and bribes for himself in the form of payments from Insys Therapeutics, Inc. (Insys) and related entities. In January 2012, the FDA approved Insys's application to sell and market a TIRF drug named Subsys to treat cancer patients experiencing breakthrough pain, which is a sudden onset of pain in cancer patients that cannot be controlled with their usual treatment regimen. Subsys is a potent opioid designed to rapidly enter a patient's bloodstream upon being sprayed under the tongue. Subsys contains fentanyl, which is a synthetic opioid pain reliever that has a high potential for abuse and addiction.

According to the plea agreement, because of the limited number of cancer patients experiencing breakthrough pain who fit the FDA-approved criteria, Insys devised an illegal kickback and bribery scheme to induce Hoffberg and others to prescribe Subsys off-label for conditions other than breakthrough pain in cancer patients. In order to conceal and disguise that kickbacks and bribes were being paid to Hoffberg to prescribe Subsys, Insys falsely designated the payments to Hoffberg as "honoraria" for purportedly providing educational programs about Subsys (the Speakers Bureau Program). Hoffberg admitted that his participation in the Speakers Bureau Program was a sham. Hoffberg often made these presentations at high-end restaurants, and to staff at the Practice and/or to persons who could not even prescribe controlled substances. Hoffberg knew that these presentations were not designed to promote any bona fide educational initiative about Subsys but rather were required to receive the honoraria.

Hoffberg was paid $66,600 by Insys and knew that these payments were kickbacks and bribes that were paid, at least in part, to induce Hoffberg to prescribe, or in exchange for Hoffberg prescribing, Subsys. As part of the scheme, through January 2018 Hoffberg prescribed Subsys to patients of the Practice who were not suffering from cancer, some of whose insurance coverage was paid for, in whole or in part, by a federal healthcare program. Further, Hoffberg admitted that he switched several other patients to Subsys from another fentanyl-based drug because of the kickbacks he received from Insys, even though he previously certified that TIRF drugs were not interchangeable. This matter was investigated by HHS-OIG, the DEA, FBI, and Baltimore County Police Department.

Patient Harm | Medicaid

- **Massachusetts Attorney General Reaches $90,000 Settlement with Milton Nursing Home Over Emergency Response Failures and Neglect of Resident Resulting in Death –Facility Allegedly Failed to Comply With Regulations Requiring Staff Competencies:** In June 2021, Milton HC Operating, LLC (Milton), a Milton, Massachusetts, nursing home, entered into a $90,000 settlement with the State Attorney General to resolve allegations that it committed neglect of a resident, which resulted in death, and failed to comply with regulations requiring nursing staff to have adequate competencies to care for residents in emergency situations.

  The settlement with Milton, which operates Brush Hill Care Center, requires the company to pay $90,000, which will be distributed to the Long-Term Care Facility Quality Improvement Fund, a fund administered by the Department of Public Health (DPH) to improve the safety and quality of care provided in long-term care facilities. Brush Hill will also be required to implement an internal compliance program and annually certify compliance with long-term care regulations to the AG's Office for a period of 3 years.

  During its investigation, the AG's Medicaid Fraud Division found that, on October 30, 2017, a resident was found unresponsive and was having difficulty breathing. The AG's Office alleges that Brush Hill failed to adequately respond to the emergency situation, that there was a delay in designating the situation as an emergency, that Brush Hill staff did not call a Code Blue on the intercom, and there was an undue delay in contacting EMTs after finding the resident unresponsive. The resident died later that day.

  This settlement also resolves allegations that Brush Hill failed to comply with long-term care regulations requiring facilities to ensure staff competencies in emergency response because staff were not sufficiently educated about emergency response protocols and Brush Hill did not maintain sufficient policies related to emergency response issues.

  In April 2021, the AG's Office also settled with Sweet Brook of Williamstown Rehabilitation and Nursing Center to resolve allegations that it failed to adequately meet the needs of and appropriately care for residents, and failed to ensure that nurses and certified nursing assistants had the necessary competencies to provide services for residents.

In 2019, the AG's Office reached a series of settlements with seven different nursing homes to resolve allegations of systemic failures at their facilities that endangered nursing home residents after investigations found that these facilities had practices that directly led to the death, injury, or potential injury to residents.

This case was investigated by the AG's Medicaid Fraud Division and Victim Services Division. DPH provided substantial assistance in the investigation.

- **Four Kentucky Hospital Workers Convicted for Reckless Abuse of an Adult:** In May 2021, the Kentucky Attorney General announced that an investigation and prosecution by his Office of Medicaid Fraud and Abuse Control resulted in the conviction and sentencing of four individuals for reckless abuse of an adult.

  The individuals— Ellyssa Klein, Sandra Nobbe, Gary Ray, and Ashley Flower—were employees of Saint Elizabeth's Hospital in Edgewood, Kentucky. Klein and Nobbe were employed as certified nursing assistants with the hospital's Behavioral Health Unit, and Ray and Flower were employed as registered nurses with the facility.

  Between July 1, 2015, and July 2, 2015, the defendants participated in and aided one another in the improper restraint of an elderly patient assigned to the Behavioral Health Unit. This restraint was accomplished by arranging furniture around the patient's medical recliner chair and placing two therapeutic water bags, each weighing in excess of thirty-five pounds, on the patient. The restraints remained in place for approximately fifteen hours.

  On April 1, 2021, Klein, Nobbe, and Ray pleaded guilty to Reckless Abuse or Neglect of an Adult, a Class A misdemeanor, and they were sentenced to 12 months in jail, conditionally discharged for 2 years. As a special condition of the plea, they agreed to resolve an administrative case with the Cabinet for Health and Family Services arising directly from their neglect of the patient. This resolution resulted in their placement on the Caregiver Misconduct Registry for a period of 7 years. They also agreed to forfeit their professional licenses.

  On May 20, 2021, Flower pleaded guilty to Reckless Abuse or Neglect of an Adult and was sentenced to twelve months in jail, conditionally discharged for 2 years. Flower agreed to forfeit her professional license as a part of her guilty plea.

  The Office of Medicaid Fraud and Abuse Control and the Cabinet for Health and Family Services investigated the case.

Pharmaceutical

- **Pharmaceutical Manufacturer Agrees to Pay $12.6 Million to Resolve Allegations it Provided Kickbacks Through Donations to a Third-Party Charity:** In May 2021, Incyte Corporation, headquartered in Delaware, agreed to pay $12.6 million to resolve allegations that it violated the False Claims Act by using a foundation as a conduit to pay the copays of Medicare and TRICARE patients taking Incyte's drug Jakafi. TRICARE is the health care program for uniformed service members, retirees, and their families.

  When a Medicare or TRICARE beneficiary obtains a prescription drug covered by a Federal health care plan, the beneficiary may be required to make a partial payment, in the form of a copayment, coinsurance, or a deductible (collectively "copays"). Congress included copays in the programs, in part, to serve as a check on health care costs, including the prices that pharmaceutical manufacturers can demand for their drugs.

Under the Anti-Kickback Statute, a pharmaceutical company cannot offer or pay, directly or indirectly, any remuneration—which includes money or any other thing of value—to induce Medicare or TRICARE patients to purchase the company's drugs. This prohibition includes the payment of patients' copay obligations. Payment of those prescriptions in violation of the Anti-Kickback Statute leads to submission of false claims to Medicare and TRICARE and violations of the False Claims Act. Essentially, Pharmaceutical companies cannot skirt the anti-kickback rules by disguising their inducements to Federally-insured patients as charitable donations.

Incyte sells Jakafi, a medication approved to treat myelofibrosis in 2011 and approved to treat other disorders after 2014. Incyte allegedly was the sole donor to a fund that was opened by a nonprofit foundation in November 2011 to assist only myelofibrosis patients. After the fund opened, the government alleges that from November 2011 through December 2014, Incyte used its influence as the sole donor of the fund to have the foundation pay the copays of Medicare and TRICARE patients taking Jakafi that did not have myelofibrosis, and thus were not eligible for assistance from the fund. Incyte managers allegedly pressured the foundation, through phone calls and emails, to provide economic assistance to these ineligible patients, and Incyte's contractor helped ineligible patients to complete their applications that were submitted to the fund for assistance. The government alleges that through this conduct, Incyte caused false claims for Jakafi to be submitted to Medicare and TRICARE.

The civil settlement includes the resolution of claims brought under the qui tam or whistleblower provisions of the False Claims Act by Justin Dillon, a former compliance executive at Incyte.

The investigation was conducted by HHS-OIG and the Department of Defense (DOD)-OIG.

- **Seven Charged for Roles in a $110 Million Compound Drug Scheme:** In June 2021, a compound pharmacy owner, three marketers, a referring physician and two clinic office staff were taken into custody in connection with a multimillion-dollar health care fraud and kickback scheme.

  A Federal grand jury sitting in McAllen returned a 15-count indictment charging John Ageudo Rodriguez, Mohammad Imtiaz Chowdhury, his father Dr. Tajul Shams Chowdhury, and Alex Flores Jr., all of McAllen, Texas; Hector DeLaCruz, Jr., of Edinburg; Araceli Gaona of Mission; and Erika Hernandez Salinas of Donna.

  Rodriguez was the owner of Pharr Family Pharmacy (PFP) and from May 2014 to September 2016, PFP allegedly billed various Federal health care programs more than $110 million, including claims that were false, fraudulent, and the result of illegal kickbacks.

  According to the indictment, Mohammad Chowdhury, Flores and DeLaCruz were purported marketers for PFP—who were the conduits for several million dollars in kickbacks relating to the referral of prescriptions for high-reimbursing compound drugs to the pharmacy. In numerous instances, the marketers allegedly received kickbacks from Rodriguez, which they shared with referring physicians.

  Dr. Chowdhury is a physician with a medical practice in Edinburg known as Center for Pain Management, according to the charges, while Gaona and Salinas were employees at the clinic. The indictment alleges Mohammad Chowdhury paid kickbacks to his father for referring prescriptions to PFP, including prescriptions for high-reimbursing compound drugs that were not medically necessary nor what the patients wanted. Gaona and Salinas are charged with conspiring to pay and receive kickbacks and conspiracy to commit money laundering in connection with their alleged receipt of kickbacks to help coordinate the flow of prescriptions from the medical clinic to the pharmacy.

  The indictment alleges Rodriguez and his co-conspirators targeted specific health care benefit programs known to pay high reimbursements for compound drugs, such as Federal Employee's Compensation Program, TRICARE, Medicare, and various private insurance plans.

As part of the scheme, Rodriguez allegedly provided PFP marketers with prefilled prescription pads intended to be given to physicians. The charges allege these included compound drugs and other prescription items that would yield the highest possible reimbursement to PFP, without regard to medical necessity.

If convicted of health care fraud and conspiracy to commit health care fraud, they face up to 10 years in prison and a maximum $250,000 and possibly $500,000. The penalty for conspiracy to pay and receive illegal kickbacks is 5 years with a $25,000 maximum fine. Those charged and convicted of conspiracy to commit money laundering face up to 20 years in prison and fine of up to $500,000.

HHS-OIG, the U.S. Postal Service-OIG, FBI, Defense Criminal Investigative Service (DCIS), Department of Labor-OIG, Veterans Affairs-OIG, the Texas Health and Human Services-OIG, and Texas MFCU conducted the investigation.

- **Mississippi Physician Sentenced for Receipt and Distribution of Misbranded Drugs:** In May 2021, Benjamin Franklin Sanford, Jr., a Starkville, Mississippi, physician, was sentenced to 3 years of probation for receiving misbranded drugs in interstate commerce and distributing them with the intent to defraud his patients. In addition to the term of probation, Sanford was ordered to forfeit $105,323, pay a fine of $95,000 and pay restitution in the amount of $377,545.

  According to court documents, Sanford—who owned and operated Starkville Internal Medicine—ordered and received foreign versions of prescription drugs that were shipped from overseas to his clinic between April 2013 and June 2018. The drugs included versions of Prolia, Boniva, and Aclasta, which had not been approved by the U.S. Food and Drug Administration (FDA). These drugs were administered to patients of Starkville Internal Medicine without their knowledge that the drugs were foreign versions of the subject drugs, which were not FDA approved.

  The FDA Office of Criminal Investigations and HHS-OIG investigated the case.

- **Queens Pharmacy Owner Sentenced to 36 Months in Prison for Health Care Fraud and Narcotics Distribution – Defendant Falsely Claimed He Was a Pharmacist and Distributed Over 10,000 Oxycodone Pills:** In May 2021, Harris Hussnain, the owner of a pharmacy in Queens, was sentenced to 36 months in prison for his participation in a health care fraud conspiracy, distribution of Oxycodone and illegal financial transactions. Hussnain pleaded guilty to the charges in September 2020.

  Between July 2016 and December 2019, Hussnain falsely claimed to be the pharmacist at New Moon Pharmacy in South Richmond Hill. Although Hussnain lawfully owned the business, he was not a licensed pharmacist and was not permitted to dispense prescription medications to patients. Hussnain operated the pharmacy on a daily basis, dispensing prescription medications for years with no medical oversight, including controlled substances and over 10,000 Oxycodone pills, billing Medicare and Medicaid for the medications dispensed. Hussnain paid a co-conspirator, Nisha Diler, a licensed pharmacist, to represent herself as the full-time pharmacist despite the fact that she visited the pharmacy only sporadically. Hussnain filed, and caused Diler to file, falsified paperwork with government entities in New York State in order to cover up Diler's absences from New Moon Pharmacy. Between 2016 and 2019, Medicare and Medicaid reimbursed New Moon Pharmacy approximately $3 million for pharmaceutical claims. Hussnain transferred significant amounts of the reimbursed funds to accounts in his and his family's names. In September 2020, Diler pleaded guilty to conspiring to defraud Medicare and Medicaid and subscribing a false tax return.

  This case was investigated by HHS-OIG, DEA, the Internal Revenue Service-Criminal Investigation (IRS-CI), the New York Office of the Medicaid Inspector General, and the New York City Police Department, and brought as part of the Medicare Fraud Strike Force.

Pharmaceutical | Patient Harm

- **El Paso Doctor Indicted for Distributing Controlled Substances and Health Care Fraud Resulting in Five Deaths:** In May 2021, Federal authorities arrested Dr. Brian James August of El Paso, Texas, for allegedly committing health care fraud and distributing controlled substances that resulted in the overdose deaths of five individuals.

  A 15-count Federal grand jury indictment charged Dr. August with five counts of distribution of a controlled substance resulting in death or serious bodily injury, five counts of distribution of a controlled substance and five counts of health care fraud resulting in death. Upon conviction, Dr. August faces 20 years to life in federal prison for the drug charges resulting in death; up to 20 years in Federal prison for each of the remaining drug charges; and up to life in Federal prison for each of the health care fraud charges.

  The indictment alleges that between December 2012 and March 2018, Dr. August, who practiced Physical Medicine and Rehabilitation aka “physiatry,” prescribed and dispensed controlled substances, including methadone, fentanyl, hydromorphone, morphine, hydrocodone, and oxycodone, outside the usual course of medical practice and without legitimate medical purpose, resulting in the deaths of five victims. Dr. August is also alleged to have committed health care fraud by billing for services he did not perform.

  The DEA and FBI investigated this case with assistance from HHS-OIG, the Texas Department of Public Safety Special Investigation Services, and the Texas MFCU as part of the Organized Crime Drug Enforcement Task Forces (OCDETF) investigation called “Operation Murder He Wrote.”

- **Two Arkansas Physicians Sentenced to a Total of 150 Months in Federal Prison for Prescription Fraud Resulting in Patient Deaths:** In May 2021, two Arkansas physicians were sentenced on one count each of Distribution of a Controlled Substance without an Effective Prescription. According to court documents, on December 18, 2019, Cecil W. Gaby of Fort Smith, a licensed physician in the State of Arkansas, pleaded guilty to acting and intending to act outside the usual course of professional practice without a legitimate medical purpose in dispensing a Schedule II controlled substance namely, oxycodone, to an individual, thereby causing the death of the individual. Between January 2016 and July 2018, Gaby was an owner and operator of the Hinderliter Pain Clinic in Barling, Arkansas and from July 2018 through November 2018, was owner and operator of the Gaby Medical Clinic in Fort Smith, Arkansas. From January 2016 through November 2018, Gaby issued more than 11,000 prescriptions for opioids and/or benzodiazepines. Gaby prescribed approximately 1,156,044 dosage units of Schedule II controlled substances to 347 patients (3,332 pills per patient over the course of 2 years); 98 percent of Gaby’s patients were prescribed at least one opioid (hydrocodone, oxycodone, methadone, etc.); 94 percent of Gaby’s patients received either multiple narcotics or a combination of narcotics and sedatives; and 27 percent of Gaby’s patients were age 40 or younger.

  Evidence in the case revealed that Gaby issued a large number of prescriptions without a legitimate medical purpose and not in the usual course of professional practice. From 2016 through 2018, several of Gaby’s patients died of drug overdose or related causes. As part of his plea, Gaby admitted that prescriptions he issued directly resulted in the death of one of his patients. Gaby was sentenced to 120 months in Federal prison followed by 3 years of supervised release.

  Robin Ann Cox of Rogers, was employed by the Arkansas Medical Clinic (AMC) in Rogers, Arkansas. Cox and the owner of AMC contacted the DEA by telephone to report that prescriptions from Cox's previous employment had been fraudulently written and filled. Cox specifically identified a prescription for a patient written and filled on May 17, 2019, and a prescription for a patient dated May 19, 2019 and filled on May 20, 2019. During the investigation

into these prescriptions, the DEA discovered that the prescriptions were for Schedule II opioid medications, and that Cox had written one of the prescriptions while meeting with the patient in the parking lot of a restaurant in Fort Smith, Arkansas. The prescription was not written in conjunction with an appropriate medical examination and therefore was issued outside the course of a legitimate medical practice. Cox was sentenced to 30 months in Federal prison followed by 3 years of supervised release.

The DEA, DEA Diversion Little Rock, FBI, HHS-OIG, Arkansas State Medical Board, and local law enforcement investigated this case.

P-STIM

- **Healthcare Practitioners to Pay over $1 Million to Resolve False Claims Act Liability Arising from Billing of P-Stim Devices:** In June 2021, three separate healthcare providers within the Western District of Texas agreed to pay over $1.05 million collectively to resolve liability under the False Claims Act for the alleged improper billing of electro-acupuncture devices.

  These providers – Ledger Foot & Ankle, P.A of Harker Heights, Superior Physical Medicine of Round Rock and Precision Spine and Pain Management of San Antonio – billed Medicare and/or TRICARE for the implantation of neuro-stimulators, a surgical procedure that usually requires an operating room and is reimbursable by federal healthcare programs. In these matters, the procedure billed actually involved a non-surgical, non-invasive application of the devices that is non-reimbursable by federal healthcare programs.

  Between February 2018 and January 2020, Dr. Harold Ledger, DPM, of Harker Heights, through his practice, Ledger Foot & Ankle, P.A., billed Medicare for the application of ANSiStim devices to beneficiaries as though they were implantable neurostimulators. Certain Medicare beneficiaries were identified as also having TRICARE benefits that were further billed to the program as the secondary insurer. Dr. Ledger will pay a total of $535,000.00 to resolve his liability under the False Claims Act.

  Between December 2016 and September 2018, SPR Medical Group (formerly known as Atlas Medical Group), d/b/a Superior Physical Medicine, (Superior) billed Medicare for the application of ANSiStim and STIVAX devices as though they were implantable neurostimulators. Following a Medicare audit of two neurostimulation procedures, Superior initiated a full repayment of the Medicare funds received for those two claims and conducted an internal audit of all claims. Superior self-disclosed claims improperly billed and has agreed to pay a total of $338,151 to resolve any potential liability under the False Claims Act.

  Between March 1 and April 2019, Dr. Yurii Borshch, through his practice Precision Spine and Pain Management, billed Medicare for the application of ANSiStim devices to beneficiaries as though they were implantable neurostimulators. During the pendency of the investigation and settlement negotiations, Dr. Borshch initiated refund payments to Medicare for the identified claims and paid a total of $183,190 to resolve potential liability under the False Claims Act.

  These matters were investigated by HHS-OIG.

Telemedicine

- **Two Montana Nurse Practitioners Admit Telemedicine Scheme to Defraud Medicare of More Than $18 Million:** In April 2021, two nurse practitioners in Montana admitted to charges that they conspired to defraud Medicare of millions of dollars in a scheme in which they received money to sign fraudulent orders for orthotic braces.

  Janae Nichole Harper of Kalispell, Montana, pleaded guilty to conspiracy to commit health care fraud. Harper was a licensed nurse practitioner in Montana, Missouri, Nevada, South Carolina, and Wyoming and was enrolled as a medical provider with Medicare.

  Mark Allen Hill of Edinburg, North Dakota, whose address of record for participation in the Medicare program was in Cut Bank, Montana, pleaded guilty on to conspiracy to commit health care fraud. Hill was a licensed nurse practitioner in Montana, Iowa, Maine, Minnesota, North Dakota, South Dakota, and Washington.

  Hill and Harper each face a maximum 10 years in prison and a $250,000 fine.

  Harper and Hill were among those indicted in a historic national health care fraud and opioid enforcement action announced by DOJ on September 30, 2020. The enforcement action involved 345 charged defendants across 51 Federal districts, including more than 100 doctors, nurses and other licensed medical professionals.

  In court documents filed in Harper's case, the Government alleged that from November 18, 2017 through July 16, 2019, Harper worked with certain staffing and telemedicine companies to commit health care fraud and received money to sign brace orders that were prepared by telemarketers who had no medical training or certification. Harper routinely signed these orders for Medicare beneficiaries regardless of medical necessity. Harper signed approximately 7,673 brace orders, which resulted in approximately $8.26 million billed to Medicare, of which Medicare paid over $4.3 million. Harper was paid at least $94,395 for the orders she signed.

  In court documents filed in Hill's case, the Government alleged that from October 15, 2017 to April 24, 2019, Hill worked with certain staffing and telemedicine companies to commit health care fraud and received money to sign unnecessary brace orders for Medicare beneficiaries regardless of medical necessity, often without ever talking to the Medicare beneficiary to determine whether the braces were medically necessary. Hill signed approximately 7,097 brace orders, which resulted in over $10.05 million billed to Medicare, of which Medicare paid over $5.05 million. Hill was paid at least $124,900 for the orders he signed.

  The enforcement actions were led and coordinated by the Criminal Division, Fraud Section's Health Care Fraud Unit, in conjunction with its Health Care Fraud and Appalachian Regional Prescription Opioid (ARPO) Strike Force program, and its core partners, the U.S. Attorneys' Offices, HHS-OIG, FBI, and DEA.

Transportation | Medicaid

- **45th Statewide Grand Jury Charge Four in $10 Million Medicaid Non-Medical Transportation Fraud Scheme:** In June 2021, four individuals were charged for their role in a $10 million Medicaid fraud scheme. The scheme involved overcharging Pennsylvanians for non-medical transportation plans that were often unused or unreliable. These charges come as the result of a 2-year Grand Jury investigation.

  Jason Alexandre, Earlson Satine, Natasha Hudson, and Rex Barr were each charged for their role in defrauding Medicaid by overbilling services offered by their respective businesses.

The Office of Attorney General began investigating these individuals in 2019, after the Pennsylvania Department of Human Services and a managed care organization separately reported that two service coordination agencies were billing large amounts of money for services never provided. The investigation uncovered similar practices by a third agency that was discovered to be associated with the others. The service coordination businesses were owned by Jason Alexandre, Earlson Satine, and Natasha Hudson.

The investigation revealed that each business used a non-medical transportation service provider called Rides Your Way, owned by Rex Barr. The service coordination agencies enrolled their participants in Rides Your Way's expensive non-medical transportation subscription plans, despite the services being unnecessary and rarely used. Between 2017 and 2019, the three service coordination agencies received over $7.9 million from Medicaid, supposedly for reimbursement for services provided by Rides Your Way. However, during that same time period, Rides Your Way only provided a total of 1,712 rides to Medicaid consumers. This meant each Rides Your Way ride cost taxpayers an average of more than $4,600. Alexandre and Satine additionally overbilled Medicaid in excess of $2 million in other services they did not provide.

Alexandre, Satine, and Barr also operated multiple shell businesses to hide their fraud and more easily withdraw cash from their scheme. One associate tasked with managing a shell business testified that she was repeatedly instructed to deposit checks and withdraw cash for Barr and Satine.

This case was investigated by Pennsylvania MFCU and will be prosecuted by Deputy Attorney General.

Other enforcement activities can be found at the following site:
https://oig.hhs.gov/fraud/enforcement/criminal/index.asp.

Recent Medicaid enforcement activities can be found at the following site:
https://oig.hhs.gov/fraud/enforcement/state/index.asp.

Trends

Defense Health Agency

Key 2020 Risk Assessment Program Risks, based on recent historical trends:

- Applied Behavioral Analysis (ABA) - Impossible Days & RBTs performing service and billing under BCBA
- Excessive Opioids/Potentiators Prescribers - Beneficiaries with high MME linking to prescribers
- Telemedicine & Related Ancillary Costs (RX, DME, ABA, Labs, etc.)
- Laboratory and Durable Medical Equipment Orders - Without a valid patient provider relationship
- Compound Drugs - Foot Baths
- Skilled Nursing Facilities - Upcoding Therapy Resource Utilization Groups
- Acute Hospitals - Referring providers focusing on Physician Groups - Orthopedic and Cardiology

FBI

COVID-19 Related:

- The Federal Bureau of Investigation (FBI) has identified multiple health care fraud schemes by bad actors seeking to take advantage of the currently overburdened health care system and the public's fear over the COVID-19 pandemic. These fraud schemes target both government and private health insurers as well as private individuals and capitalize on the currently overburdened healthcare system to commit traditional health care fraud schemes such as overbilling, upcoding, unbundling of services, and billing for services not provided and/or which were not medically necessary. As of 7 April 2020, some of the more prevalent health care fraud-related schemes identified by the FBI are as follows:

    - Fraud actors are engaging in schemes to obtain and exploit individuals' identity information, including their insurance information (PII), and personal health information (PHI). The FBI has identified fraud schemes involving robo-callers who promote or offer "free" test kits, fake cures or drugs that allegedly offer protection against COVID-19, in exchange for PII or cash.
    - Fraudsters are also obtaining information and identifying potentially vulnerable targets from social media posts where someone discusses symptoms, health status or frustrations over treatment and testing. Fraudsters use this information to obtain PPI and PHI that is later used in fraudulent billing schemes or selling medically unnecessary and fake cures or protection from the virus to the unsuspecting and vulnerable public.
    - Calls and home visits offering telemedicine consultations for COVID-19 are also on the rise, with bad actors soliciting insurance information, most notably Medicare ID numbers and/or other PPI like driver license information.
    - Health care providers have also been paying kickbacks to marketers (recruiters) in exchange for patient referrals, services such as promoting/selling fake COVID-19 test kits, supplies and equipment, and for signing/forging prescriptions that are medically unnecessary/outside the normal bounds of medical practice.
    - The FBI has also noted scammers creating fake shops, websites, social media accounts, and email addresses claiming to sell medical supplies currently in high demand and in short supply such as N-95 respirator masks, gloves, and other personal protective equipment (PPE). In these scams, suppliers solicit money up front, pocketing the money without providing the supplies.
    - There has been an uptick in prescribing of hydroxychloroquine, an anti-malaria drug being touted as a potential cure for COVID-19. The FBI is aware some physicians are prescribing hydroxychloroquine for themselves and their families without medical necessity. This has resulted in short supplies with adverse consequences for those who need the drug for lupus, rheumatoid arthritis, and other chronic conditions.

Non-COVID-19 Related:

- The Federal Bureau of Investigation (FBI) has identified a scheme in which fraud actors create and sell fraudulent home health care aide training certifications to individuals who have not completed the required training hours prior to working as a home health care aide. The number of hours required by states for home health care aides varies, but all states require at least the federal 75-hour minimum training requirement. Home health aides who are caring for patients without the required training could put the health and well-being of patients at risk and could lead to home health agencies unintentionally or intentionally billing government and private health insurers for services provided by untrained and uncertified individuals.

HHS-OIG

- **Ambulance Transportation:** OIG continues to investigate cases in which ambulance providers misrepresent patient conditions and then obtain fraudulent Medicare payments for transport. Often, the transportation is medically unnecessary and/or the charges are upcoded. Swapping arrangements between medical institutions and ambulance companies also continue to be an area of concern throughout the ambulance industry.

- **CARES Act:** The Coronavirus Aid, Relief, and Economic Security (CARES) Act is designed to provide emergency financial assistance to millions of Americans who are suffering the economic effects resulting from the COVID-19 pandemic. One source of relief provided by the CARES Act is the Provider Relief Fund (PRF), which is intended to support American families, workers, and health care providers in the battle against the COVID-19 outbreak. The funding is provided by general and targeted distributions. A portion of the funding is meant to be distributed to health care providers who provide treatment for uninsured COVID-19 patients (Uninsured Portal/UP).

  HHS-OIG has identified fraud schemes where providers are not verifying that patients actually have health insurance and are billing those individuals as uninsured, billing add-on respiratory pathogen panels to the COVID-19 tests (unnecessary) to increase reimbursement, performing antibody tests and advertising those tests as rapid COVID-19 tests, and performing COVID-19 tests and submitting claims through the program but never providing the patient with test results.

  While collaborating with the Health Resources and Services Administration (HRSA), Our investigative priority is to ensure that the allotted funding is being utilized for its intended purpose.

  For more information related to the Provider Relief Fund and the Uninsured Portal, please see the following:
  - **Provider Relief Fund:** https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html
    - *Program Information, Terms and Conditions, and FAQs (ongoing updates)*
  - **Uninsured Portal:** https://www.hrsa.gov/coviduninsuredclaim
    - *Program Information and Requirements*

- **Community Mental Health Centers:** OIG is investigating cases where CMHCs bill Medicare/Medicaid for services not provided and for services provided by non-licensed individuals. OIG investigations also continue to identify scenarios where CMHCs bill for mental health services but instead provide, at best, recreational adult day care. This not only clogs the system for those in need of legitimate care, but it could also drive up overall health care costs. As mental health services are expanding under the Affordable Care Act, the task of rooting out fraud, waste, and abuse will only become more vital.

- **COVID-19:** OIG continues to see an uptick in hotline complaints regarding COVID-19-related fraud schemes. OIG and its law enforcement partners have investigated a steady stream of allegations of COVID-19-related fraud and abuse. Fraudsters are using telemarketing, text messages, social media platforms, and door-to-door visits to perpetrate scams to steal money and personal information from vulnerable people, exploiting fear and confusion. Fraudsters are offering COVID-19 test, COVID-19 vaccines, HHS grants, and Medicare prescription cards in exchange for personal details, including Medicare information. These services are unapproved and illegitimate. OIG remains vigilant and committed to holding perpetrators of fraud schemes accountable.

- **June 2021 DOJ, OIG Press Release:** Federal and State Officials Advise COVID-19 Vaccine Providers in Wisconsin that Individuals Seeking Vaccinations Cannot be Charged

  OIG has alerted the public to suspicious activity related to vaccines, including:
  - requests for payment to get a vaccine, including deposits or fees;
  - requests for payment or offers of money to enhance ranking for vaccine eligibility (i.e., getting a better spot in line or on a wait list);
  - offers to sell or ship doses of vaccine for payment; and
  - offers to purchase vaccine record cards containing personally identifiable information, and offers of money to participate in a vaccine survey.

- **Durable Medical Equipment:** OIG continues to investigate cases involving telemarketers contacting Medicare beneficiaries for DME providers. These telemarketers use misleading techniques to obtain Medicare beneficiary information. Some telemarketers may offer something for free in exchange for beneficiaries providing their personal and Medicare information. Once this information is obtained, the DME provider often bills for DME that is medically unnecessary or never provided. This telemarketing is used for several types of DME, including diabetic testing supplies and orthotics. OIG has also seen an increase in cases involving prosthetics that are medically unnecessary and/or never provided, and cases involving the fraudulent billing for repairs of power mobility devices.

- **Genetic Testing:** Data shows that genetic testing billing continues to be in the billions of dollars and growing. While there are increasing legitimate uses for genetic testing, there are also increasing fraud cases. For example, OIG is seeing testing performed for diseases the patient could not possibly have, including those that would not first appear in an older Medicare population, such as obvious birth defects.

  Unscrupulous labs are inserting themselves into health fairs, church events, or senior living centers to market their products and/or obtain a saliva swab sample from Medicare beneficiaries. The swab sample is obtained first, then the lab finds someone to approve the test. Often the signing provider for the genetic test is not the patient's treating physician and approval is obtained via telemedicine without an in-person encounter, medical necessity, or any prior patient-provider relationship.

  Copays for the test are typically waived as a means of incentivizing the patient into participating. In some instances, the aggregated waived copays for these tests can amount to hundreds or thousands of dollars. Patients are told these tests are "at no cost to you"; however, if insurance denies the claim, the beneficiary is responsible to pay thousands of dollars out of pocket.

  Genetic testing fraud alert. OIG issued a fraud alert for consumers on June 3, 2019. The fraud alert can be viewed at: https://oig.hhs.gov/fraud/consumer-alerts/alerts/geneticscam.asp.

- **Home Health:** A large number of home health fraud schemes investigated by OIG often involve kickbacks being paid to patients, patient recruiters, ordering physicians, and other healthcare providers. In some areas of the country, fraudulent home health providers are utilizing very aggressive recruiting techniques to solicit patients. Once a patient is recruited, the agency then sends a referral to a physician who signs the paperwork without first seeing the patient. Commonly, these same patients actually have primary care physicians who aren't aware they are receiving home health. In addition, Medicare is being billed for patients who are not confined to the home in a large number of home health fraud schemes investigated by OIG.

- **Hospice Services:** OIG continues to see fraud related to hospice providers. These cases often involve fraudulently certifying patients as eligible for hospice services when they are not. OIG also continues to see hospice providers billing for a higher level of care for patients who do not need it and did not receive it. Hospice fraud schemes frequently also involve kickbacks to beneficiaries and health care providers alike. Hospice providers are also utilizing aggressive marketing techniques to solicit beneficiaries.

- **Medicaid:** As a result of the public health emergency (PHE), various legal authorities grant States emergency flexibilities critical to ensuring that States can respond to the crisis expeditiously to protect and serve the general public. Over the course of the COVID-19 PHE, State Medicaid and CHIP agencies adopted many flexibilities offered by CMS to respond effectively to their local outbreaks.

  To support health care delivery while minimizing face-to-face encounters during the COVID-19 PHE, many states accelerated adoption of services provided by telehealth, across a wide variety of disciplines.

  We continue to identify bad actors who have taken advantage of additional telehealth flexibilities by billing for items and services that were not rendered or medically necessary.

  Appearing below are fraud trends that OIG continues to see as areas of concern in the Medicaid space.

  - *COVID-19 Death Diagnosis within Medicaid*—OIG is monitoring providers and States for possible reclassifying of COVID-19 death diagnoses due to increased reimbursements.

  - *Administration of payments to providers within Medicaid*—Based on emerging trends, States appear to be increasingly vulnerable to hackers changing Payment/Electronic Funds Transfer (EFT) forms. Two-factor authentication is not utilized when changing payment accounts for providers. It is for this reason that WA, IA, TX, OH and more States have been affected.

  - *Community Mental Centers or Psychosocial Rehabilitation*—There are potentially 300 subjects in Miami-Dade County involved in this type of fraud with close to 1 billion paid in 2020.

  - *Cases involving mental health counselors and their billing of individual psychotherapy*—Listed below are summaries of what we are seeing:

    - Non-supervisory counselors—i.e., counselors who do not have the requisite license to supervise other counselors—claiming to be supervisors and hiring counselors or counselor interns. All claims that are submitted for services rendered by employees have the employer's NPI number;

    - Individual psychotherapy claimed for beneficiaries receiving group therapy for summer or after school programs, such as basketball camp and military-style boot camp; and

    - Providers obtaining the PII of all the siblings and children of a family and then billing all members of the family for psychotherapy services even though only one child is receiving treatment.

- **Medical Identity Theft:** Although OIG has seen an increase in the involvement of organized crime entities who utilize stolen or compromised beneficiary and provider identities, medical identity theft can also be carried out by healthcare providers and other individuals who have access to patient records and personally identifiable information. Cyberintrusions and new challenges that Electronic Health Records may pose to the protection of beneficiaries' personal health information are also elements that can factor into the increase in medical identity theft. OIG recognizes the increased risk identity theft poses to our Medicare and Medicaid beneficiaries and providers and will continue to actively investigate allegations and instances of medical identity theft related to Medicare and Medicaid fraud.

- **Medicare Part C / Medicare Managed Care:** OIG continues to see an increase with the Medicare Part C investigations involving risk adjustment fraud. These cases involve Medicare Advantage plans submitting risk-adjustment payments for medical conditions that their members were not treated for, and may not even have. These investigations also involve upcoding members' diagnoses to exaggerate the severity of the members' condition, in order to submit a diagnosis code that triggers a higher risk adjustment score. In addition, OIG is working jointly with SSA to investigate individuals who are receiving disability benefits fraudulent and have enrolled in Part C plans. As a result of their fraudulent disability benefits, these individuals gain eligibility into the Medicare program, and enroll in various Medicare Advantage plans to receive medical coverage.

- **Pharmaceutical:** OIG continues to see the trend of opioid prescribing go down. The OIG Office of Evaluations and Inspection submitted a list of prescribers that are still hitting metrics. Three years ago it was over 400 providers; now it is less than 100. The good trend continues. However, OIG is still seeing some individual providers grossly over prescribing and is working cases on these individuals.

  OIG is still seeing individuals taking advantage of the COVID regulatory relaxation. Very expensive non-controlled specialty drugs are being billed and not dispensed. OIG continues to look out for these kinds of frauds.

  COVID fraud complaints continue to come in on the vaccine front. Typical COVID-19 vaccine fraud schemes include fraudsters who offer vaccines that do not exist or cause the beneficiary to become a victim of identity theft, which can lead to other Medicare frauds such as billing for medically unnecessary tests, medications, and DME supplies. In addition, OIG is also seeing fake vaccine ID cards proliferating, which is being looked into.

- **Telehealth:** As OIG has seen increased activity related to "telefraud" schemes, it is important to distinguish those schemes from telehealth fraud. In the last few years, OIG has conducted several large investigations of fraud schemes that inappropriately leveraged the reach of telemarketing schemes in combination with unscrupulous doctors conducting sham remote visits to increase the size and scale of the perpetrator's criminal operations. In many cases, the criminals did not bill for the sham telehealth visit. Instead, the perpetrators billed fraudulently for other items or services, like durable medical equipment or genetic tests. OIG will continue to vigilantly pursue these "telefraud" schemes and monitor the evolution of scams that may relate to telehealth.

Agency Statistics

CMS Statistics

- CMS's provider screening and enrollment efforts in Medicare have had a significant impact on removing ineligible providers and suppliers from the program. In FY 2018, CMS deactivated over 158,000 enrollments and revoked about 1,950 enrollments.

- The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary, public-private partnership between the Federal Government, state and local agencies, law enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations to identify and reduce fraud, waste, and abuse across the healthcare sector. The HFPP is currently made up of 168 members: 79 Private Payers, 44 State & local partners, 27 Law enforcement, 13 Associations, and 5 Federal partners. The HFPP currently receives data on 104 million individuals with insurance, but our potential is even greater. Currently, the HFPP reviews data on 1 in 3 Americans; the partnership's potential goal expands to 3 in 4 Americans.

- In April 2018, CMS created a law enforcement partnership forum, the Major Case Coordination (MCC), designed so that CMS and law enforcement partners can quickly and systematically collaborate on fraud health care schemes. Through this collaboration, CMS is able to maximize efforts to identify, investigate, and pursue providers who might otherwise endanger program beneficiaries or commit fraud on federal programs. The goal of the MCC process is to ensure the right tool (CMS's administrative tools vs law enforcement tactics) is applied to the right case, at the right time (to not interfere with sensitive law enforcement operations) and in the right order. CMS's efforts to identify potential fraud earlier in the process have resulted in numerous successful takedowns, marked increases in number and amount of charged health care cases and hundreds of millions of dollars in increased savings related to administrative enforcement actions. As a result of these efforts, CMS achieved the following:

    - FY 2018 to FY 2019, nearly doubled total Medicare revocation savings through the revocation of bad actor billing privileges.

    - FY 2018 to FY 2019, doubled Medicare savings from law enforcement referrals.

    - In FY19, CMS investigated the largest number of cases through its first-of-its-kind healthcare fraud case coordination process with OIG, DOJ, OCIG. Over 1000 cases (25% increase from 2018) were reviewed.

    - Most and largest nationwide law enforcement takedowns ever:

        - Operation Brace Yourself: 24 individuals charged - $1.2 billion in losses – administrative action against 130 DME companies for over $1.7 billion in claims submitted
        - Operation Double Helix: 35 individuals charged – $2.1 billion in losses – suspended 11 clinical laboratories. CMS proactively identified, deactivated, and reissued 220,000 Medicare Beneficiary Identifier (MBI) numbers on the new Medicare card that were compromised in nationwide fraud schemes. This safeguard effort prevented an estimated $1.1 billion that could have been at risk to the Medicare program.

Defense Health Agency Statistics

- 875 investigative cases were actively managed
- 329 new cases were opened
- 353 cases were closed
- 1,485 leads/requests for assistance were responded to
- TRICARE judgments and settlements for calendar year 2019 totaled $125,905,105
- CY 2019 prepayment duplicate denials amounted to $594,743,871

HHS-OIG-OI Fiscal Year-To-Date Statistics (Quarterly)

- For fiscal year-to-date ending June 30, 2021*, we reported 339 criminal and 344 civil and Civil Monetary Penalty Law actions against individuals or entities that engaged in health-care-related offenses. We also reported $1.046 billion in HHS investigative receivables and $661.51 million in non-HHS investigative receivables (such as from our work related to the States' share of Medicaid restitution) for a total of $1.707 billion in total healthcare-related investigative receivables.

  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.

  *Please note that the above reported numbers represent the first three quarters of fiscal year 2021.

HHS-OIG Statistics (Recent)



Additional information regarding HHS-OIG statistics can be found in the Semi-Annual Report (SAR) to Congress.* The SAR describes OIG's work identifying significant risks, abuses, deficiencies, remedies, and investigative outcomes related to HHS programs and operations during the 6-month periods ending March 31st and September 30th. Semiannual reports are intended to keep the Secretary and the Congress fully and currently informed of significant findings and recommendations by OIG.
The SAR can be viewed at: https://oig.hhs.gov/reports-and-publications/semiannual/index.asp

**Please note that the numbers appearing in the above graphic representation reflect the first two quarters of FY 2021. It is for this reason that they differ from the numbers appearing in the previous section, which represent the first three quarters of fiscal year 2021.*

Additional information regarding law enforcement statistics and activities regarding health care fraud and abuse can be found in the Health Care Fraud Abuse and Control Program Report.

Sanctions, Debarments, Suspensions

HHS-OIG Exclusions from Participation in Federal Health Care Programs

- OIG has the authority to exclude individuals and entities from Federally funded health care programs pursuant to sections 1128 and 1156 of the Social Security Act and maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals and Entities (LEIE). The effects of an exclusion are outlined in the *Updated Special Advisory Bulletin on the Effect of Exclusions From Participation in Federal Health Programs*, but the primary effect is that no payment will be provided for any items or services furnished, ordered, or prescribed by an excluded individual or entity. This includes Medicare, Medicaid, and all other Federal plans and programs that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan).

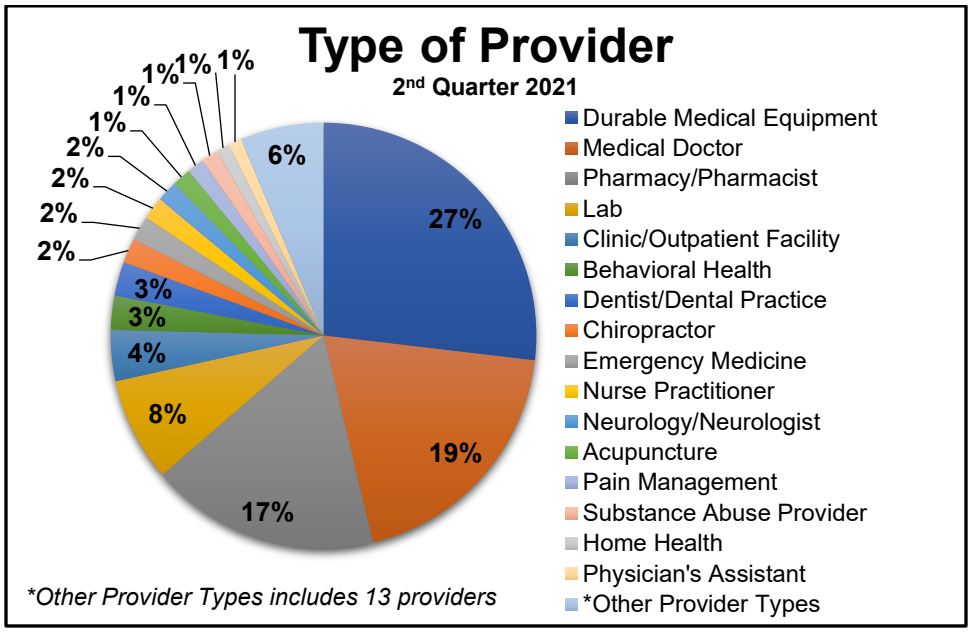
- Exclusions: For the fiscal year-to-date ending June 30, 2021*, OIG excluded 1302 entities from participation in Federal health care programs.

  **Please note that the above reported Exclusion number represents the first three quarters of fiscal year 2021.*

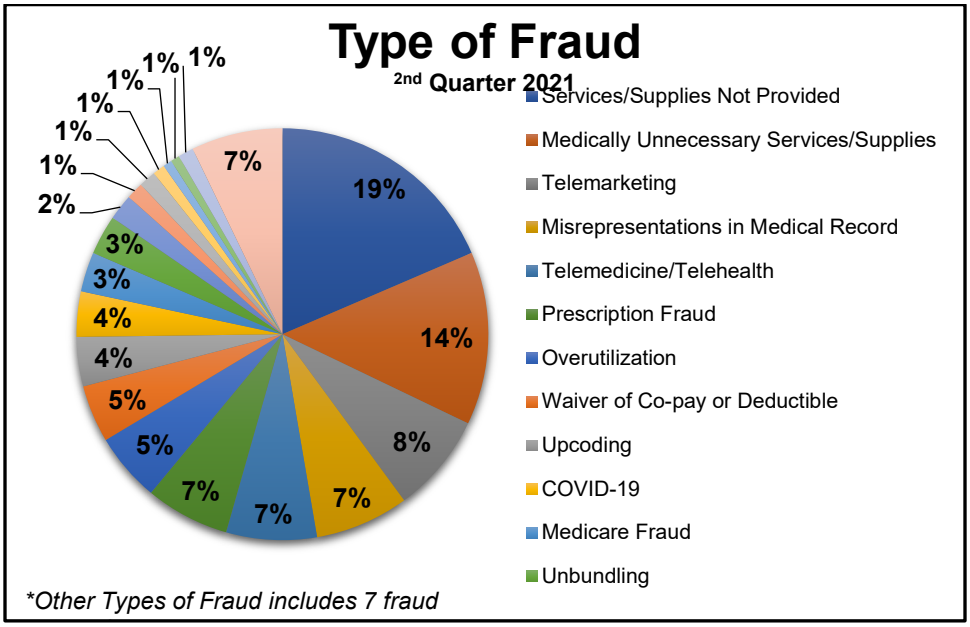
  - Searchable exclusion lists are available on OIG's Web site at: https://exclusions.oig.hhs.gov/.
  - Additional information regarding exclusions to include Special Advisory Bulletins and other guidance can be found at: https://oig.hhs.gov/exclusions/index.asp.

SIRIS® QUARTERLY STATISTICS

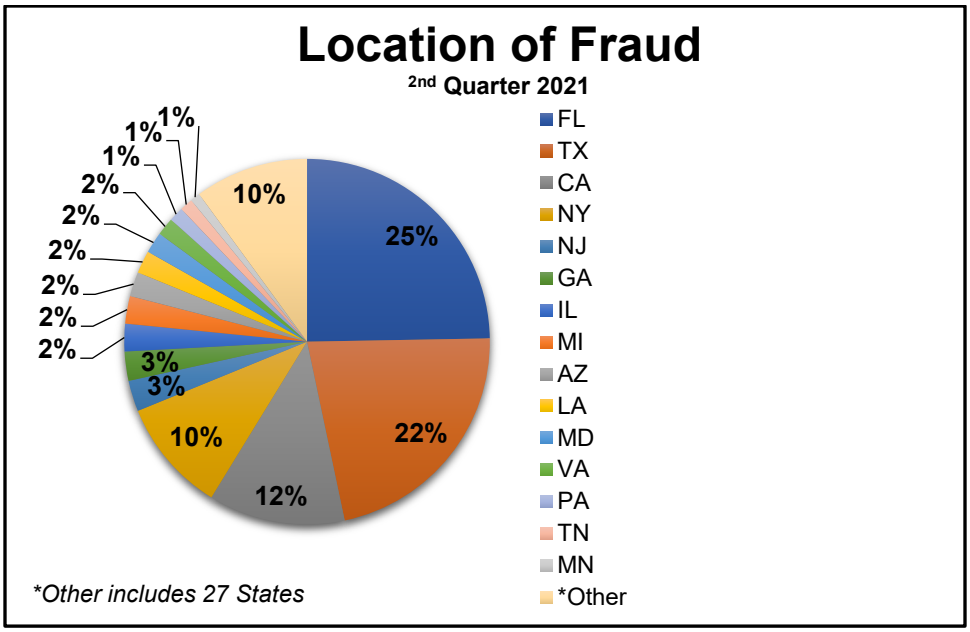
The following pie charts represent the compilation of the statistical reporting over the last 3 months (April - June 2021) of records entered into SIRIS.



Observation: *When compared to the previous quarter, the top four Types of Providers remained the same, however, DME moved to the topmost reported type of provider. Physical Therapy/Therapist dropped off the chart from the 5th position in the first quarter.*



Observation: *When compared to the previous quarter, the top two categories remained constant from the 1Q2021 report. Telemarketing jumped from the 8th most reported type of fraud in 1Q2021 to the 3rd position.*



Observation: *As usual, Florida, Texas, California, and New York remained static in the top four Locations of Fraud reported. New Jersey rose from the 13th position to the 4th position in 2Q2021.*

Note: *The location of fraud represents the state in which the provider's office is located. While most fraud occurs in the provider's office, please keep in mind that the actual fraud may have occurred in many locations/states.*

ADDITIONAL RESOURCES & STATE NEWSLETTERS

PA – Insurance Fraud Section Newsletters

- April 2021
- May 2021
- June 2021

Pennsylvania Insurance Fraud Prevention Authority Fraud Stories Newsletters

- 2Q2021

Department of Justice Press Releases

- California's Second-Largest Skilled Nursing Facility Operator Pays $450,000 to Resolve False Claims Act Allegations, 6/29/2021
- Owner of Two Pharmacies Pays $300,000 to Resolve Controlled Substances Act Violations, 6/28/2021
- Surgical Care Affiliates and Orlando Surgery Center Agree to Pay $3.4 Million To Settle False Claims Act Liability, 6/28/2021
- Connecticut Addiction Medicine Provider Pays $1 Million to Settle Improper Billing Allegations, 6/25/2021
- Jefferson County Doctor Sentenced to Federal Prison for Health Care Fraud Violations, 6/24/2021
- Justice Department Reaches Settlement Agreement with Physicians Group in El Paso Over Allegations of Violating the False Claims Act, 6/23/2021
- Tennessee Doctor Pleads Guilty to Hydrocodone Distribution Resulting in Death, 6/23/2021
- Acting U.S. Attorney Hairston and AG Stein Announce $330,000 Health Care Fraud Settlement with Triad Doctor, 6/22/2021
- Pair Plead Guilty to Kickback Scheme, 6/21/2021
- Oklahoma City Doctor Pays $325,000 to Settle Civil Penalty Claims, 6/21/2021
- Kentuckiana Physician and Nurse Practitioner Found Guilty of Conspiracy to Distribute Controlled Substances, Conspiracy to Commit Health Care Fraud, And Conspiracy to Commit Money Laundering, 6/19/2021
- Seven charged for roles in a $110 million compound drug scheme, 6/17/2021
- Former Doctor Sentenced for Unlawfully Distributing Controlled Substances, 6/16/2021
- Manhattan Doctor Sentenced to Nearly 5 Years in Prison for Accepting Bribes and Kickbacks in Exchange for Prescribing Fentanyl Drug, 6/16/2021
- Camden County Man Sentenced to One Year in Prison for Theft of Government Funds with Stolen Electronic Benefits Machine, 6/15/2021
- United States Files Suit Against California Skilled Nursing Chain and its Owner for Allegedly Paying Illegal Kickbacks to Physicians, 6/15/201
- Former Ridgway Physician Agrees to Forgo Practicing Medicine and Pay Penalty to Resolve Allegations that He Prescribed Controlled Substances without a Medical License, 6/165/2021
- U.S. Recovers $650,000 from Local Providers Who Billed Medicare and Medicaid for Screening Tests Not Performed, 6/14/2021
- Niagara Falls Woman Pleads Guilty to Conspiring to Defraud Health Insurance Company, 6/14/2021
- Two PA Chiropractic Practices Pay Over $800,000 to Resolve Alleged False Claims Act Liability Arising from Billing of P-Stim Devices, 6/11/2021
- Pain doctor pays to settle allegations arising from false billing, 6/11/2021
- Wrongful billing results in $2.6M settlement and 10-year exclusion from federal health care programs, 6/8/2021

- Court Orders Toledo Pharmacy and Two Pharmacists to Stop Dispensing Dangerous Doses and Combinations of Opioids and Other Controlled Substances, 6/7/2021
- Counselor Involved in Wide-Ranging Medicaid Fraud Scheme Pleads Guilty, 6/4/2021
- Physician Pleads Guilty in Medicaid Fraud Conspiracy, 6/2/2021
- Insurance Broker Sentenced for $3.8 Million Fraud Scheme, 5/27/2021
- Final Defendant Sentenced in $80 Million Health Care Fraud Conspiracy, 5/27/2021
- Two Arkansas Physicians Sentenced to a Total of 150 Months in Federal Prison for Prescription Fraud, 5/27/2021
- El Paso Doctor Indicted for Distributing Controlled Substances and Health Care Fraud Resulting in Five Deaths, 5/27/2021
- Queens Pharmacy Owner Sentenced to 36 Months in Prison for Health Care Fraud and Narcotics Distribution, 5/27/2021
- DOJ Announces Coordinated Law Enforcement Action to Combat Health Care Fraud Related to COVID-19, 5/26/2021
- Greensboro Physician and Pain Management Practice to Pay $500,000 to Resolve Allegations of Health Care Fraud, 5/26/2021
- SavaSeniorCare LLC Agrees to Pay $11.2 Million to Resolve False Claims Act Allegations, 5/21/2021
- Texas Man Pleads Guilty to Receiving Kick Back Payments in Exchange for Referrals to OK Compounding, 5/2/2021
- Manhattan U.S. Attorney Files Suit Against Eleven Skilled Nursing Facilities and Their Management Company, Owner, And A Senior Employee for Fraudulently Billing Medicare for Unnecessary Services, 6/2/2021
- Employee of Autism Services Agency Pleads Guilty to Health Care Fraud and Identity Theft Offenses, 6/2/2021
- Medical Doctor Sentenced for Drug Trafficking and Health Care Fraud Offenses, 6/2/2021
- Jury Convicts West Virginia Doctor of Drug Distribution, 5/28/2021
- Insurance Broker Sentenced for $3.8 Million Fraud Scheme, 5/27/2021`
- Final Defendant Sentenced in $80 Million Health Care Fraud Conspiracy, 5/27/2021
- Two Arkansas Physicians Sentenced to a Total of 150 Months in Federal Prison for Prescription Fraud, 5/27/2021
- El Paso Doctor Indicted for Distributing Controlled Substances and Health Care Fraud Resulting in Five Deaths, 5/27/2021
- DOJ Announces Coordinated Law Enforcement Action to Combat Health Care Fraud Related to COVID-19, 5/26/2021
- Cardiologist Sentenced to Prison for Decade-Long Health Care Fraud Scheme, 5/20/2021
- Manager of Pain Clinic, Her Boyfriend, and Customers Facing Federal Charges for a Drug Distribution Conspiracy, 5/19/2021
- Starkville Physician Sentenced for Receipt and Distribution of Misbranded Drugs, 5/19/2021
- Owner of Company Providing Prosthetics and Orthotics Materials to Walter Reed National Military Center Pleads Guilty to Federal Charges in Maryland for Paying Gratuities, 5/18/2021
- Doctor's Employee Admits Role in $24.8 Million Kickback Scheme, 5/18/2021
- Georgia woman admits participation in scheme to obtain fraudulent reimbursements for medical equipment and genetic testing, 5/18/2021
- U.S. Attorney's Office and HHS-OIG Advise COVID-19 Vaccine Providers Not to Charge Individuals Seeking COVID-19 Vaccines, 5/17/2021
- Alleged Fraudsters Charged with Bribing Patients and Fraudulently Billing Medicaid for Psychosocial Rehabilitation Services, 5/17/2021
- Dentists to Pay $3.1 Million to Resolve Allegations They Submitted False Claims for Services Not Provided to Underprivileged Children, 5/14/2021
- Maryland Woman Sentenced to Prison for Defrauding Medicaid Program Out of Hundreds of Thousands of Dollars, 5/12/2021
- Dubuque Care Facility's Owner Agrees to Repay Federal Medicaid Funds to Resolve Allegations Relating to COVID-19 Screening Procedures, 5/10/2021

- University of Miami to Pay $22 Million to Settle Claims Involving Medically Unnecessary Laboratory Tests and Fraudulent Billing Practices, 5/10/2021
- Doctor Charged with Illegally Distributing Opioids, Defrauding Health Care Benefit Programs, 5/7/2021
- Physician Indicted in $6 Million Medicare Fraud Scheme, 5/7/2021
- Alabama Doctor Sentenced for Conspiracy to Distribute a Controlled Substance, 5/5/2021
- Neurosurgical Associates, LTD and Dignity Health, D/B/A St. Joseph's Hospital, paid $10 Million to Resolve False Claims Allegations, 5/5/2021
- Incyte Corporation to Pay $12.6 Million to Resolve False Claims Act Allegations for Paying Kickbacks, 5/4/2021
- Texas woman handed significant sentence for health care fraud scheme, 5/4/2021
- Three Florida Men Charged in $46 Million Health Care Fraud, Kickback, and Money Laundering Conspiracy, 5/3/2021
- Neurosurgeon and Two Affiliated Companies Agree to Pay $4.4 Million to Settle Healthcare Fraud Allegations, 5/3/2021
- Multiple Defendants Sentenced in a Major Compounding Pharmacy Fraud Conspiracy, 4/29/2021
- Two Inglewood Women Get Prison Sentences for Health Care Fraud and Fraudulently Billing Medi-Cal for Substance Abuse Counseling, 4/28/2021
- Mississippi Man Indicted for Wire Fraud and Health Care Fraud, 4/28/2021
- Owner of Child Autism Services Agency Pleads Guilty to Health Care Fraud, 4/28/2021
- Fayetteville, North Carolina Physician Agrees to Pay $300,000.00 to Resolve Allegedly Fraudulent Medicare and Medicaid Claims Involving Autonomic Nervous System Tests, 4/28/2021
- Final four sentenced in $189M Health Care Fraud Scam, 4/23/2021
- Five People Charged, Two Others Admit Guilt, in $93 Million Health Care Fraud Scheme, 4/22/2021
- Las Vegas Businessman Pleads Guilty to His Role in $13 Million Fraud Upon North Carolina Medicaid Program, 4/21/2021
- Gloucester Man Admits Trafficking Prescription Pills and Engaging in SNAP Fraud, 4/22/2021
- Sacramento Area Home Health Care and Hospice Agencies Owner Pleads Guilty to Conspiring to Defraud Medicare, 4/22/2021
- Two Montana nurse practitioners admit telemedicine scheme to defraud Medicare of more than $18 million, 4/21/2021
- Manager of Hospice and Home Health Companies Sentenced to Prison for Role in $150 Million Health Care Fraud Scheme, 4/21/2021
- Las Vegas Businessman Pleads Guilty to His Role in $13 Million Fraud Upon North Carolina Medicaid Program, 4/22/2021
- Gloucester Man Admits Trafficking Prescription Pills and Engaging in SNAP Fraud, 4/22/2021
- Sacramento Area Home Health Care and Hospice Agencies Owner Pleads Guilty to Conspiring to Defraud Medicare, 4/22/2021
- Two Montana Nurse Practitioners Admit Telemedicine Scheme to Defraud Medicare of More Than $18 Million, 4/21/2021
- Manager of Hospice and Home Health Companies Sentenced to Prison for Role in $150 Million Health Care Fraud Scheme, 4/21/2021
- Comprehensive Pain Specialists and Former Owners Agree to Pay $4.1 Million to Settle Fraud Allegations, 4/21/2021
- Queens Pharmacy Owner Pleads Guilty to Health Care Fraud, 4/21/2021
- Massachusetts Eye and Ear Agrees to Pay $2.6 Million to Resolve False Claims Act Allegations, 4/20/2021
- Howard County Physician Pays More Than $660,000 to Resolve False Claims Act Allegations of Fraudulent Billing, 4/19/2021
- Six Individuals Sentenced for Nearly $8 Million Health Care Fraud Involving Northern Virginia Pharmacies, 4/16/2021

- Sandusky Physician Charged with Prescribing Medically Unnecessary Controlled Substances and Health Care Fraud, 4/16/2021
- Winston-Salem NC Pain Management Company to Pay $789,292.95 to Resolve Allegations of False Claims for Urine Drug Testing, 4/16/2021
- Louisiana Doctor Sentenced to Prison for Conspiring to Receive Health Care Kickbacks, 4/15/2021
- Patient Recruiter Sentenced to Prison for $3.3 Million Cancer Genetic Testing Fraud Scheme, 4/14/2021
- Louisiana Doctor Sentenced to Prison for Conspiring to Receive Health Care Kickbacks, 4/15/2021
- Mandeville Man Is Charged with Health Care Fraud and Aggravated Identity Theft, 4/13/2021
- Doctor Sentenced To 9 Years in Prison in Widespread Scheme to Defraud Medicare And Other Health Insurance Providers of Millions Of Dollars, 4/13/2021
- Home Health Company Pays $28K for Employing "Excluded" Individual, 4/12/2021
- 20 Months in Prison for Memphis Area Man Offering Kickbacks, 4/9/2021
- South Carolina's Largest Urgent Care Provider and its Management Company to Pay $22.5 Million to Settle False Claims Act Allegations, 4/8/2021
- CARES Act Fraud Investigations Identify Twenty-Three Individuals Targeting Thirty-One Million Dollars, 4/8/2021
- Colorado Physician Charged for Misappropriating Thousands from Three Different COVID Relief Programs, 4/8/2021
- Behavioral Health Provider Pays $273K to Settle Improper Billing Allegations, 4/6/2021
- Florida Counseling Center Owner and Provider Convicted Of Medicaid Fraud, Conspiracy, False Statements, And Identity Theft, April 6, 2021
- Dominican National Admits to Trafficking Fentanyl, Health Care Fraud, ID Theft, 4/5/2021
- Owners and Former Employee of Heath Care company Facing Federal Charges for Allegedly Paying Kickbacks to Homeless Patients and Fraudulently Billing Medicaid, 4/2/2021
- Israeli National Sentenced to 30 Months in Prison for Bail Jumping and Participating in Conspiracy to Distribute Unlicensed Prescription Drugs, 4/1/2021

HHS-OIG

- COVID-19 Had a Devastating Impact on Medicare Beneficiaries in Nursing Homes During 2020, 6/20/2021
- Medicare Home Health Agency Provider Compliance Audit: Caretenders of Jacksonville, LLC, 5/28/2021
- Georgia Generally Ensured That Nursing Facilities Reported Allegations of Potential Abuse or Neglect of Medicaid Beneficiaries and Prioritized Allegations Timely, 4/12/2021
- Message from HHS-OIG Leadership on the COVID-19 Vaccination Program and Provider Compliance, 4/15/2021
- List of Excluded Individuals and Entities
- State Enforcement Actions

State News/Press Releases

- **California**
  - Attorney General Bonta Issues Consumer Alert Warning Californians About Counterfeit COVID-19 Vaccination Record Cards, 5/19/2021
- **Connecticut**
  - Connecticut Behavioral Health Provider Pays $273k to Settle Improper Billing Allegations, 4/6/2021
- **Florida**
  - Medicaid Provider Arrested for Stealing More Than $5,000 from Taxpayer-Funded Program, 6/25/2021
  - Attorney General Moody Secures $2 Million Payment from Medicrea to Resolve False Claims and Kickback Allegations, 6/23/2021
  - Florida Nurse Arrested for Exploiting a Senior, 4/23/2021
  - Owner of a Gadsden Home Service Provider Arrested for More Than $50,000 in Medicaid Fraud, 4/16/2021
- **Idaho**
  - Attorney General Announces Idaho's Participation in $300 Million Settlement with Drugmaker Indivior, 5/12/2021
- **Kentucky**
  - Attorney General Cameron Announces Investigation by His Office Leads to Conviction of Bracken County Woman for Attempted Forgery, 6/18/2021
  - Attorney General Cameron Announces Conviction of Four Hospital Workers for Reckless Abuse of an Adult, 5/27/2021
- **Louisiana**
  - Over $3.6M In Suboxone Settlement Funding Headed to Louisiana, 4/30/2021
- **Maryland**
  - Prince George's County Physician Indicted for Medicaid Fraud and Drug Distribution, 6/16/2021
  - President and Vice President of Mental Health and Substance Abuse Treatment Programs Plead Guilty to Medicaid Fraud, 6/15/2021
  - Attorney General Frosh Charges Prince George's County Pharmacist for Allegedly Operating a Pill Mill, 5/27/2021
- **Massachusetts**
  - AG Healey Reaches $90,000 Settlement with Milton Nursing Home Over Emergency Response Failures and Neglect of Resident Resulting in Death, 6/24/21
  - AG Healey Secures $6.65 Million From Drug Company for Falsely and Aggressively Marketing Suboxone, 5/3/2021
  - AG Healey Reaches Settlement with Williamstown Nursing Home for Failure to Adequately Care for Residents, 4/21/2021
  - Former Waltham Nursing Home Admissions Director Pleads Guilty, Sentenced for Embezzlement Scheme, 4/20/2021
- **Missouri**
  - Missouri Attorney General Obtains $150,000 Medicaid Fraud Settlement, 6/25/2021
  - Missouri Attorney General Obtains $300,000 Settlement in Medicaid Fraud Case, 5/4/2021
  - Old Town Pharmacy Owner and Pharmacy Technician Indicted on 34 Counts Related to Medicaid Fraud, Forgery, Identity Theft, 4/26/2021
- **Nevada**
  - Attorney General Ford Announces Sentencing of Keyana Lanice Jamill Carter for Medicaid Fraud, 6/3/2021
  - Attorney General Ford Announces Sentencing of Former Medicaid Provider Business Owner Lavell James Worthy, Jr., 5/19/2021
- **New Hampshire**
  - Michael Maggiacomo and Tina Allen Indicted for Medicaid Fraud, 4/29/2021

- **New Mexico**
  - AG Balderas Secures Prison Sentence of Former Personal Care Organization Owner Who Defrauded Medicaid Program of Over $445,000, 4/12/2021
- **New York**
  - Attorney General James Teams with Federal Prosecutors to Make Dental Clinics Agree to Pay $2.7 Million for Alleged Use of Unsterilized Tools, 5/25/2021
- **North Carolina**
  - AG Stein and Acting U.S. Attorney Hairston Announce $330,000 Health Care Fraud Settlement with Triad Doctor, 6/23/2021
  - Attorney General Josh Stein Announces Health Care Fraud Sentencing, 6/28/2021
  - Attorney General Josh Stein Announces Sentencing for $13 Million Medicaid Fraud, 5/19/2021
  - Attorney General Josh Stein Announces $300,000 "Operation You've Got Nerve" Settlement, 4/29/2021
  - Attorney General Josh Stein Announces $60,000 Medicaid Fraud Settlement, 4/19/2021
- **Pennsylvania**
  - AG Shapiro, 45th Statewide Grand Jury Charge Four in $10 Million Medicaid Fraud Scheme, 6/15/2021
  - AG Shapiro: Nursing Home Manager Pleads to Recklessly Endangering Three Residents, 6/2/2021
- **South Dakota**
  - Aberdeen Woman Sentenced in Identity Theft Case, 5/18/2021
- **Tennessee**
  - Nurse Aide Arrested, Charged with Theft, Financial Exploitation, 6/14/2021
- **Texas**
  - New Texas Bills Target Deceptive Health Care Marketing, State of Reform, 4/15/2021
- **Wisconsin**
  - Milwaukee County Doctor Charged with Identity Theft and Medical Assistance Fraud, 5/18/2021

Articles of Interest

- Justice Department zeros in on EHR fraud after record number of false claims: 5 details, Becker's IT Health, 6/30/2021
- Vein doctor's federal court case delayed again for evidence review, plea talks, Macomb Daily, 6/30/2021
- Justice Department Reports Record Number of Health Fraud Cases, Bloomberg Law, 6/29/2021
- Department of Justice Increases Focus on COVID-19 Fraud, Lexology, May 18, 2021
- Texas Man Sentenced to 20 Years for $150 Million Hospice Fraud Scheme. EIN Presswire, May 12, 2021
- Top 10 Compliance Priorities for HHS, Becker's Hospital Review, April 23, 2021
- Florida woman charged with submitting altered COVID-19 test to travel portal, The Virgin Island Daily News, April 22, 2021
- Propelled by COVID-19, State Governments Attempt to Keep Up with Telemedicine Innovation and Digital Health Platform, The National Law Review, April 21, 2021
- Justice Department takes action against COVID-19 fraud, The Highland County Press, April 2, 2021

LexisNexis Fraud of The Day

- A Staggering Array of Fraud
- Pharma Pusher
- Fraud on the RISE
- Massive Scheme Laid to Rest
- Terminal Fraudster
- Knowledge vs. Wisdom
- The Stakes Are High

- **COVID Fraud:**
  - Fraud and All That Jazz
  - Twisted Testing
  - The Only One in The World
  - A New Low in Used Car Deals
  - One Little Mistake
  - Wheels Stopped Turning
  - From Lovebirds to Jailbirds

- **Medicaid Fraud:**
  - A Losing Hand
  - Small-Time Schemer Avoids the Big House
  - Many Chickens Come Home to Roost
  - Feloniously Ever After
  - Cheap and Felonious
  - A Fall from Grace
  - The Birth of a Fraudulent Scheme

- **Medicare Fraud:**
  - Two Doctors, a Nurse, and a CEO
  - Double-Dealing Scammers
  - Hemorrhaging Money
  - A DAM Shame
  - Ill-Equipped

- **Workers Comp and Disability Fraud**
  - That's the Way the Cookie Crumbles

AGENCY DESCRIPTIONS

The FBI is the primary agency for exposing and investigating health care fraud, with jurisdiction over both federal and private insurance programs. We use our analytic expertise to identify key trends and tap into our investigative partnerships with federal, state, and local agencies, as well as our relationships with national groups and associations, to uncover fraud. Our field offices also proactively target fraud through coordinated initiatives, task forces and strike teams, and undercover operations. The FBI works closely with its federal, state, and local law enforcement partners; the Centers for Medicare and Medicaid Services; and other government and privately sponsored program participants to address vulnerabilities, fraud, and abuse.

The U.S. Department of Health and Human Services – Office of Inspector General's (HHS-OIG) mission is to protect the integrity of HHS programs as well as the health and welfare of program beneficiaries. Since its 1976 establishment, OIG has been at the forefront of the Nation's efforts to fight fraud, waste, and abuse in Medicare, Medicaid, and more than 100 other HHS programs. HHS-OIG is the largest inspector general's office in the Federal Government, with more than 1,700 employees dedicated to combating fraud, waste, and abuse and to improving the efficiency of HHS programs. Click here for more information regarding HHS-OIG.

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. State-of-the-art tools and technology assist OIG investigators around the country and help OI meet its goal of being the world's premier health care law enforcement agency. Click here for more information regarding the Office of Investigations.

The Office of Labor Racketeering and Fraud Investigations (OLRFI) is responsible for conducting criminal, civil, and administrative investigations relating to violations of Federal laws, rules or regulations pertaining to Department of Labor (DOL) programs, grants, contracts, and operations, as well as allegations of criminal activity and serious misconduct on the part of DOL employees. In relation to healthcare fraud, the OLRFI investigates fraudulent activity in Office of Workers Compensation Programs (OWCP). These investigations focus on fraud activity involving four major disability programs: Federal Employees' Compensation Act Program, Energy Employees Occupational Illness Compensation Program, Coal Mine Workers Compensation Program (Black Lung), and Longshore and Harbor Workers' Compensation Program.

The Office of Personnel Management Office of the Inspector General (OPM OIG) is responsible for preventing fraud, waste, and abuse within all OPM administered programs through audits and investigations. From a health care perspective, the OPM/OIG has primary oversight of the Federal Employees Health Benefits Program (FEHBP), a Federally funded health care program. The FEHBP, established by the Federal Employee Health Benefit Act (FEHB), Public Law 86-382, is the largest employer-based health care program in the United States.

The VA Office of Inspector General, Office of Investigations, conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for healthcare benefits (to include identity theft), and other fraud relating to the delivery of health care to millions of veterans and their dependents.

The Office of Medicaid Program Integrity (MPI) is located within the Office of the Inspector General and fulfills the Agency for Health Care Administration's (Agency) state and federal law obligations related to preventing, detecting, and auditing fraud, abuse, and waste, as well as initiating the recovery of overpayments in the Medicaid program, as defined in s.409.913, F.S. and 42 CFR 455. These broad categories of program integrity activities align with the organizational units of detection, prevention, recoupment, managed care, and administrative support within the Office of Medicaid Program Integrity (MPI). MPI is a unique component of the Agency's Office of Inspector General in that most Florida inspectors general offices do not house an administrative enforcement arm within their structure.