2019 NHCAA

Awards Program

October 16, 2019 | Nashville, Tennessee

NHCAA

2019 NHCAA AWARDS COMMITTEE

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NHCAA

EXCELLENCE IN PUBLIC AWARENESS AWARD

National Health Care Anti-Fraud Association

Highmark Blue Cross Blue Shield

Financial Investigations & Provider Review Team

Opioid Epidemic Education Program

The National Health Care Anti-Fraud Association is proud to honor **Highmark Blue Cross Blue Shield** and its **Financial Investigations & Provider Review Team** as this year's recipient of the **Excellence in Public Awareness Award** for its Opioid Epidemic Education Program. This award is bestowed annually to an organization or individual who has demonstrated an unwavering dedication to raising public awareness about the problem of health care fraud.

Determined to help the communities it serves face the well-documented opioid epidemic, Highmark instituted an Opioid Epidemic Education Program focused on students, parents, and facilitators that examines the dangers of opioid abuse. The program depends largely on a presentation developed by Highmark's Financial Investigations & Provider Review Team to educate about opioids, fentanyl, heroin, and deadly drug combinations to empower individuals in saying "No." It also addresses the obvious and not-so-obvious signs of abuse and addiction, the difference between helping and enabling, how the stigma of addiction can keep people sick, and other valuable resource information.

The program has been successful in building community partnerships, allowing Highmark to reach more than 6,500 students and educators across western Pennsylvania with its message. With the 2019-2020 school year underway, Highmark is already actively scheduling presentations through the end of the year to bring opioid awareness to thousands more.

Combatting the opioid epidemic demands a multifaceted approach. In addition to its community education program, Highmark has also put into place a Designated Pharmacy Program and the use of proactive data analytics for high-risk opioid prescribers.

CONGRATULATIONS TO

KURT SPEAR
Vice President
Financial Investigations & Provider Review
Highmark Blue Cross Blue Shield

JAMES BURGESS
Vice President
Payment Integrity
Gateway Health Plan

AMY BLETTNER, CFE
Lead Fraud Analyst
Financial Investigations & Provider Review
Highmark Blue Cross Blue Shield

RICHARD KAPLAN, MD
Allegheny Health Network

BRIANNE MCCARTHY
Director
Financial Investigations & Provider Review
Highmark Blue Cross Blue Shield

AMBER BRENNAN
Senior Fraud Analyst
Financial Investigations & Provider Review
Highmark Blue Cross Blue Shield

BRIAN DEMPSEY
Intelligence Research Specialist
United States Department of Justice
Drug Enforcement Administration

NHCAA Medical Director Award
National Health Care Anti-Fraud Association

Daniel J. Nicoll, MD, FACP, CFE, AHFI

National Medical Director for Fraud and Abuse

Cigna

The National Health Care Anti-Fraud Association is proud to honor **Daniel Nicoll, MD, FACP, AHFI, CFE** as this year's recipient of the **Medical Director of the Year Award**.

Dr. Nicoll has been the National Medical Director for Fraud and Abuse at Cigna since 2013, where he has worked diligently to partner with internal and external stakeholders to combat health care fraud. In his role, he recommends changes to medical policies and procedures to limit abuse and losses; hosts monthly educational seminars for fellow medical directors; supports Cigna's SIU legal team by assisting with depositions; and regularly advises Cigna on referrals to law enforcement and state licensing boards.

Based upon Dr. Nicoll's dedication and expert advice as Chair of Cigna's Credentialing Committee and his many years of service as Chairman of the Peer Review Committee of his local county medical society, Dr. Nicoll serves as a critical resource to determining which cases need referral to licensing bodies, organizations, health systems, and law enforcement. He presents to local medical societies and to classes at public health schools. Dr. Nicoll was also recently appointed as the Chair of NHCAA Medical Director's Advisory Group.

Dr. Nicoll exemplifies a dedicated commitment to combating health care fraud both internally at Cigna and externally throughout the health care anti-fraud community.

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THE JOHN MORRIS VOLUNTEER SERVICE AWARD

National Health Care Anti-Fraud Association

Aneta C.D. Andros, AHFI

Director, SIU Analytics

Cigna

The National Health Care Anti-Fraud Association is proud to honor **Aneta Andros**, Director, SIU Analytics, Cigna, as the 2019 recipient of **The NHCAA John Morris Volunteer Service Award**, first established in 2018.

Aneta Andros, AHFI has proven herself to be a steadfast supporter of NHCAA, serving as a dedicated faculty member, trainer, and advisor to NHCAA for the past decade. She actively engages on a regular basis with NHCAA staff, committees, and interest groups; she provides enthusiastic guidance on training content, presents on a wide range of topics, and supports her team's participation in the Association's information-sharing activities.

Her expertise has influenced the development of numerous NHCAA educational programs and initiatives from the Boot Camp and Excellence in Leadership programs to the Annual Training Conference. Through her participation in NHCAA training programs, she promotes the professional growth of health care fraud analysts and investigators in our industry, and she helps guide NHCAA through the ever-changing world of health care fraud to ensure that the Association's programs are timely and relevant.

In particular, Aneta has been instrumental in growing the data analytics programming offered by NHCAA. As a member of the Annual Training Conference committee, she has worked to develop multiple pre-conference programs, and as the co-chair of the newly formed Data Analytics Interest Group, she helps foster discussion and guides relevant topics and presentations.

Aneta's knowledge of the health care anti-fraud industry and her enthusiasm for education has made her a vital asset to NHCAA. She gives her time and advice freely to staff, and she has enhanced investigation efforts across the country through her speaking and mentoring.

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SIRIS

INVESTIGATION OF THE YEAR

HONORABLE MENTION

National Health Care Anti-Fraud Association

United States of America v. Benjamin Rosenberg, DDS

The National Health Care Anti-Fraud Association is proud to honor the individuals who worked together to investigate a scheme involving a dentist who submitted false and fraudulent claims to federal, state, and private insurers as this year's recipients of the **SIRIS Investigation of the Year Award – Honorable Mention**.

Due largely to the collaboration and investigative persistence of the involved law enforcement agencies and insurers, a dental fraud scheme perpetrated by Benjamin Rosenberg was uncovered, investigated, and prosecuted. A SIRIS Request for Investigative Assistance (RIA), entered by the FBI, helped to identify additional victims. In March 2018, Rosenberg was charged with six counts of health care fraud and two counts of aggravated identity theft for billing for crowns and fillings that were never provided to patients.

As a result of the overwhelming evidence uncovered by the investigative team, Rosenberg pleaded guilty and was sentenced to 40 months in federal prison. He was ordered to pay almost $1.5 million in restitution.

CONGRATULATIONS TO

UNITED STATES DEPARTMENT OF JUSTICE
Criminal Division, Fraud Section

Emily Z. Culbertson, *Trial Attorney*

UNITED STATES DEPARTMENT OF JUSTICE
Federal Bureau of Investigation
Washington Field Office, Northern Virginia Resident Agency

Jessica Marrone, *Special Agent*
Joseph Parker, *Special Agent*

UNITED STATES DEPARTMENT OF DEFENSE
Defense Health Agency, Office of Program Integrity

Christopher F. Del Mastro, MS, CFE, *Health Care Fraud Specialist*

DELTA DENTAL OF CALIFORNIA
Federal Government Programs, Operations

Jana M. Riolo, *Quality Assurance Specialist*

METLIFE
Special Investigations Unit

Dorene E. Whaley, AHFI, *Senior Investigator*

UNITED CONCORDIA DENTAL
Special Investigation Unit

Sandra A. Hair, *Supervisory Investigator*

Highmark Hemophilia Specialty Pharmacy/Employer Group Investigation

The National Health Care Anti-Fraud Association is proud to present the investigative and legal teams involved in the Highmark Hemophilia Specialty Pharmacy/Employer Group Investigation with this year's **SIRIS Investigation of the Year Award**.

The investigative team uncovered a complex scheme designed to increase revenue for a specialty pharmacy and others based on reimbursement of hemophilia factor medications. The investigation revealed that the specialty pharmacy recruited hemophiliacs and/or their family members to act as patient advocates to market the pharmacy's services to other potential recipients. The recruited hemophiliacs were required, and sometimes forced, to receive an excess volume of factor medication from the pharmacy.

The pharmacy and individuals set up a sham employer group that "employed" the recruited hemophiliacs. Within the first several months, the sham employer group (or pharmacy) submitted claims seeking reimbursement for millions of dollars, with $4.5 million in claims in just the first several weeks.

Following its investigation, Highmark rescinded the policy, took steps to assist the involved patients in obtaining appropriate insurance coverage, and filed a federal RICO lawsuit seeking to recover its damages, avoid future payments, and obtain reimbursement for its attorneys' fees and related costs. The specialty pharmacy and the other defendants denied all wrongdoing. The parties ultimately settled on confidential terms.

CONGRATULATIONS TO

HIGHMARK BLUE CROSS BLUE SHIELD
Financial Investigations and Provider Review

Holly B. Dolan, *Senior Decision Support Consultant*
Latrisha Oswald, MSFS, AHFI, CFE, *Director*
Kurt S. Spear, CFE, CISSP, CISA, CRISC, *Vice President*
Jaime Wetzel, *Fraud Consultant*

AETNA
Special Investigations Unit

Patricia Dralle, AHFI, *Senior Investigator*

ANTHEM, INC.
Special Investigations Unit

David A. Schneider, MBA, CFE, *Lead Investigator*

BLUE CROSS BLUE SHIELD OF TENNESSEE
Special Investigations Department

Connie S. Gautreaux, MS.CJ, *Senior Investigator*

HEALTH CARE SERVICE CORPORATION
Special Investigations Department

Deana G. Forrest, *Senior Analytics and Reporting Analyst*

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY
Special Investigations Department

Scott C. Johnson *CFE, Supervisor*

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INVESTIGATION OF THE YEAR

HONORABLE MENTION

National Health Care Anti-Fraud Association

United States of America v. Barry J. Cadden et al.

New England Compounding Center

The National Health Care Anti-Fraud Association is proud to recognize the United States of America v. Barry J. Cadden et al. investigation and prosecution teams with this year's **Investigation of the Year Award - Honorable Mention**.

This team of federal agencies was responsible for the investigation and prosecution of the owners and executives of New England Compounding Center (NECC), the compounding pharmacy that manufactured contaminated steroids that led to the 2012 nationwide fungal meningitis outbreak. According to the Centers for Disease Control and Prevention, the fungal meningitis outbreak infected approximately 1,000 individuals and led to 76 deaths throughout the country. It was the deadliest medication contamination case in U.S. history.

Over the past seven years, the team's extraordinary efforts have led to the convictions of numerous individuals on a variety of charges, including RICO, RICO conspiracy, conspiracy to defraud the United States, mail fraud, and violations of the Food, Drug, and Cosmetic Act.

In March 2017, Barry J. Cadden, the owner and head pharmacist of NECC, was convicted of 57 counts. In October 2017, Glenn Chin, NECC's supervising pharmacist, was convicted of 77 counts. Additional defendants were convicted, including the director of operations and three more NECC pharmacists in December 2018. Most recently, in May 2019, two NECC pharmacists were convicted of violating the Food, Drug, and Cosmetic Act.

In addition to the criminal convictions, the team successfully lobbied the Office for Victims of Crime (a part of the U.S. Department of Justice) and the Massachusetts Attorney General's Office to recognize the fungal meningitis victims as crime victims with access to the Victims of Violent Crimes Compensation Fund, and secured a $40 million federal contribution to ensure compensation for the fungal meningitis victims.

CONGRATULATIONS TO

UNITED STATES DEPARTMENT OF JUSTICE
United States Attorney's Office
District of Massachusetts

Christopher Looney, *Assistant United States Attorney*
Clare Reidy, *Paralegal*
Rachel Savas, *Paralegal*
Amanda P. M. Strachan, *Assistant United States Attorney*
George P. Varghese, *Assistant United States Attorney*

UNITED STATES DEPARTMENT OF JUSTICE
Federal Bureau of Investigation
Boston Field Office

Clayton P. Phelps, *Special Agent*
Philip M. Sliney, Jr., *Special Agent*

UNITED STATES DEPARTMENT OF JUSTICE
Consumer Protection Branch

John Claud, *Assistant Director*

UNITED STATE DEPARTMENT OF DEFENSE
Office of Inspector General, Defense Criminal Investigative Service
Boston Resident Agency

Sara Albert, *Special Agent*
Patrick J. Hegarty, CPA, CFE, *Assistant Special Agent in Charge*

UNITED STATES DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General

Jason T. Kravetz, *Special Agent*

UNITED STATES FOOD & DRUG ADMINISTRATION
Office of Criminal Investigations

Benedict Celso, *Special Agent*
David Kelly, *Special Agent*
Frank J. Lombardo, *Special Agent*
Mike Mangiacotti, *Special Agent*
Joseph A. Ridgley, *Special Agent*

Office of the Chief General Counsel

Lynn M. Marshall, *Associate Chief Counsel*

UNITED STATES POSTAL INSPECTION SERVICE
Brian Evans, *Postal Inspector*

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National Health Care Anti-Fraud Association

United States of America v. Beauchamp et al.

Forest Park Medical Center

The National Health Care Anti-Fraud Association is proud to present the United States of America v. Beauchamp et al. investigation and prosecution teams with this year's **Investigation of the Year Award**.

This case became the largest, non-drug related, criminal healthcare fraud investigation in the Northern District of Texas. The collaboration between federal agencies and private insurance carriers was critically important to the overall success of the investigation. This highly effective investigation and prosecution yielded a Federal Grand Jury indicting 21 individuals associated with Forest Park Medical Center on health care fraud-related charges in this $200 million scheme.

The case was a massive and complex undertaking involving the investigation of Forest Park Medical Center (Forest Park), a luxurious, physician-owned hospital in Dallas, Texas. Forest Park was co-founded by Alan Beauchamp, Dr. Richard Toussaint, Wade Barker, Wilton Burt, and others as an out-of-network hospital with the ability to set its own prices for services and was generally reimbursed at substantially higher rates than in-network providers. The hospital's strategy was to maximize profit for physician investors by refusing to join the networks of insurance plans for a period of time after its formation, allowing its owners and managers to enrich themselves through out-of-network billing and reimbursement. The case focused on a vast bribery conspiracy involving prominent surgeons, an out-of-network billing model, and waiver of, or reduction to, in-network levels of co-pays and co-insurance, which facilitated the billing of over a billion dollars to primarily private insurance carriers.

Ten defendants pleaded guilty to federal charges which included Barker, Beauchamp, and Toussaint. In a separate trial, a jury found Burt and other conspirators guilty for their roles in the scheme. Each defendant was convicted of various offenses some of which included conspiracy to pay and receive bribes and kickbacks, violating the Federal Anti-Kickback Statute, violating the Travel Act with a predicate underlying offense of Texas state commercial bribery, and conspiracy to commit money laundering.

CONGRATULATIONS TO

UNITED STATES DEPARTMENT OF JUSTICE
United States Attorney's Office
Northern District of Texas

Katherine E. Pfeifle, *Assistant United States Attorney*
Andrew O. Wirmani, *Assistant United States Attorney, Public Corruption Coordinator*

UNITED STATES DEPARTMENT OF JUSTICE
Federal Bureau of Investigation
Dallas Field Office

Susanna F. Shaw, *Special Agent*

UNITED STATES DEPARTMENT OF DEFENSE
Office of Inspector General, Defense Criminal Investigative Service
Dallas Resident Agency

Adam Dennick, *Special Agent*

UNITED STATES DEPARTMENT OF LABOR
Office of Inspector General

Kristina M. Picard, *Special Agent*

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Office of the Inspector General

Casey E. England, *Special Agent*
David Keagy, *Special Agent*

INTERNAL REVENUE SERVICE
Criminal Investigation

Andrew D. Bishop, *Special Agent*

AETNA
Medical Economics

Richard B. Harris, *Executive Director*

BLUE CROSS AND BLUE SHIELD OF TEXAS
Special Investigations Department

Lisa Mothershed, *CFE, Lead Investigator*
Misty G. Sellers, *Director, Analytics Consulting*
James Wilson, *Analytics and Reporting Consultant, Data Intelligence Unit*

UNITEDHEALTHCARE INVESTIGATIONS
North Texas Health Plan

Kristin K. Moore, *Vice President of Account Management*

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National Health Care Anti-Fraud Association

United States of America v. Esformes et al.

The National Health Care Anti-Fraud Association is proud to present the United States of America v. Esformes et al. investigation and prosecution teams with this year's **Investigation of the Year Award**.

From approximately January 1998 through July 2016, Philip Esformes led an extensive health care fraud conspiracy involving a network of assisted living facilities and skilled nursing facilities that he owned. Esformes bribed physicians to admit patients into his facilities, and then cycled the patients through his facilities, where they often failed to receive appropriate medical services or received medically unnecessary services. Esformes billed Medicare and Medicaid $1.3 billion in false claims.

The investigation team armed prosecutors with undercover recordings, financial documents, text messages, and testimony from convicted associates. The case was built upon conspiracy charges involving healthcare fraud, bribery, paying and receiving kickbacks, money laundering, and obstruction of justice. Esformes was convicted on 20 of the 26 charges for which he was indicted which included nine counts of money laundering, one count of conspiracy to commit money laundering, four counts of payment of kickbacks in connection with a federal healthcare program, two counts of receipt of kickbacks with a federal healthcare program, two counts of conspiracy to commit federal program bribery, one count of conspiracy to defraud the United States, and one count of obstruction of justice.

Assistant Attorney General Benczkowski called the Esformes conspiracy "one of the largest health care fraud schemes in U.S. history" and commended the prosecutors and law enforcement partners for their "professionalism and unyielding pursuit of justice on behalf of American taxpayers and vulnerable beneficiaries who, as a result of Esformes's crimes, were denied the level of care that they needed and deserved."

On September 12, 2019, Esformes was ordered to spend 20 years in federal prison. Forfeiture and restitution will be decided at a hearing in November 2019.

CONGRATULATIONS TO

UNITED STATES DEPARTMENT OF JUSTICE
United States Attorney's Office
Southern District of Florida

Daniel Bernstein, *Assistant United States Attorney*
Jessica E. Elliott, *Assistant United States Attorney*
Daren Grove, *Assistant United States Attorney*
Elizabeth A. Martin, *RN Investigative Analyst*
John Shipley, *Assistant United States Attorney*
Nalina Sombuntham, *Assistant United States Attorney*
Susan Torres, *Deputy Chief, Civil Division*

UNITED STATES DEPARTMENT OF JUSTICE
Criminal Division, Fraud Section

Drew Bradylyons, *Assistant Chief, Miami Strike Force*
Kimberly K. Coffey, *Health Care Fraud Data Analyst, Health Care Fraud Unit*
James V. Hayes, *Trial Attorney*
Allan J. Medina, *Acting Chief, Health Care Fraud Unit*
Jeremy R. Sanders, *Appellate Counsel*
Elizabeth Young, *Trial Attorney*

UNITED STATES DEPARTMENT OF JUSTICE
Federal Bureau of Investigation
Miami Field Office

Randy Culp, *CFE, CPA, Special Agent*
Mark Myers, *Special Agent*
Jonathan Ostroman, *Special Agent*
Terence G. Reilly, *Special Agent*

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Inspector General, Office of Investigations
Miami Regional Office

Ricardo M. Carcas, *CFE, Special Agent*
Julissa Monzon-Parsons, *Special Agent*
Julie Rivera, *Assistant Special Agent in Charge*
Steven Shandy, *CDAC Program Manager*
Cesar D. Zayas, *Special Agent*

Office of Inspector General, Office of Management and Policy, Chief Data Office

Lauren McNulty, *Lead Program Analyst, Division of Data Analytics*

Other Notable Cases

HEALTH MANAGEMENT ASSOCIATES, INC. (HMA) INVESTIGATION

This investigation involved a multi-disciplinary, multi-department effort that resulted in recovering over $300 million to resolve criminal charges and civil claims related to a highly complex scheme to drive up admissions without medical necessity. HMA, a former U.S. hospital chain headquartered in Naples, Florida, engaged in this corporate-driven scheme to defraud government health care programs.

LIFESTREAM HEALTHCARE ALLIANCE, LLC

The Massachusetts Medicaid Fraud Division indicted and convicted Hellen Kiago, the owner of Lifestream Healthcare Alliance, LLC, on four counts each of Medicaid False Statements and one count each of felony larceny involving home health services. The schemes involved in this case included medical necessity, correction orders, and falsifying patient records that resulted in $6 million of fraudulent billing. The defendants were found guilty on all counts and Kiago was ultimately sentenced to 2.5 years in a Massachusetts house of corrections.

MASSACHUSETTS NURSING HOME SWEEP

A sweep of seven different Massachusetts nursing homes resulted in a series of settlements to resolve allegations of systemic failures at these facilities that endangered nursing home residents. The Massachusetts Attorney General's Office investigated reports of substandard care or regulatory violations at nursing homes based on complaints referred by the Massachusetts Department of Public Health. The AG's Office found that these facilities had systemic issues that directly led to the death, injury, and/or potential injury to nursing home residents. The seven facilities were assessed a collective amount of approximately $500,000 in penalties and either agreed to compliance programs or to cease participating in Massachusetts health care programs.

MAX HEALTH MEDICAL GROUP

Robert Pomahac, a chiropractor in California, opened Max Health Medical Group, a medical practice in California that advertised a vast array of medical and non-medical services to improve a patient's well-being. All services were provided by Dr. Pomahac, but he was not qualified to render services beyond chiropractic work. Even so, this medical group knowingly billed insurers for services outside their scope, such as: physical medicine codes; such as trigger point injections, allergy testing, nerve conduction studies, and hormone injections. These billings resulted in an overpayment of more than $930,000.

UNITED STATES OF AMERICA V. ARNITA AVERY-KELLY

Dr. Arnita Avery-Kelly, a licensed podiatrist, has been found guilty on federal charges of illegally prescribing opioid painkillers and other drugs at clinic locations purporting to provide podiatric care in Sandy Springs and Lithonia, Georgia. The investigation clearly showed that Avery-Kelly was not practicing podiatry, or even legitimate pain management, as she claimed in billings, records, and files. In the end, the prosecution was able to show that Avery-Kelly was willingly exploiting opioid addicted patients, collaborating with drug dealers, and running a "pill mill" without any regard for the impact on public health.

UNITED STATES OF AMERICA V. JAMES BURKHART ET AL.

A three-year federal investigation by HHS-OIG, FBI, IRS-CI, and the United Sates Attorney's Office, Southern District of Indiana led to the sentencing of James Burkhart, former CEO of American Senior Communities, in a massive fraud, kickback, and money laundering conspiracy. For his part, Burkhart pleaded guilty to three federal felony offenses: conspiracy to commit fraud, conspiracy to violate the health care anti-kickback statute, and money laundering. All told, he and his co-conspirators funneled nearly $19.4 million in fraud and kickbacks to themselves through a web of shell companies.

UNITED STATES OF AMERICA V. SALIM DAHDAH, MD ET AL.

Salim Dahdah, a licensed cardiologist from Ohio, and his wife Cindy Dahdah pleaded guilty to health care fraud, conspiracy to commit health care fraud, and false statements relating to health care in the Southern District of Ohio. The charges accused them of unlawfully taking in more than $2 million by billing, or causing claims to be submitted, for medically unnecessary medical tests and procedures. The charges were tied to inserting dual pacemaker/defibrillator (ICD) devices in patients who did not need them, rendering medically unnecessary cardiac interventions on patients, and rendering unnecessary cardiac testing, including nuclear stress tests, on patients.

UNITED STATES OF AMERICA V. KOTHARI AND MCMENAMIN (PRIMERA MEDICAL GROUP)

A case investigated by the FBI with assistance from the Special Investigations Unit for Blue Cross Blue Shield of Georgia resulted in two defendants, Shailesh Kothari and Timothy McMenamin, pleading guilty to health care fraud charges and aggravated identity theft. This case involved billing for more than 4,500 fraudulent claims that exceeded $8.5 million. Kothari was sentenced to nearly seven years in prison and ordered to pay $1.5 million in restitution. McMenamin was sentenced to nearly eight years in prison and ordered to pay $1.5 million in restitution.

See more ▶

Other Notable Cases

UNITED STATES OF AMERICA V. ROBERT MAUGHON

Dr. Robert Maughon defrauded Medicare, Medicaid, and numerous private plans by billing for non-FDA approved and unsupervised allergy therapy. The financial impact of Dr. Maughon's fraud scheme was substantial, totaling over $14 million.

UNITED STATES OF AMERICA V. MIR

This case centers on an investigation that involved a highly sophisticated and fragmented Medicaid fraud scheme operating from 2013 to 2018. The scheme utilized provider and member medical identify theft to establish phantom dental clinics and fabricate dental claims, which resulted in over $1 million in Medicaid funds being paid out for services not rendered.

UNITED STATES OF AMERICA V. PALMA (OPERATION TRUE BILL)

Operation True Bill was a multi-year investigation targeting the owners of multiple medical billing companies in the Miami area that billed private insurance companies on behalf of fraudulent physical therapy clinics located across the United States. The two billing companies, Billing USA Corp. and American Fast Services Corp., submitted approximately $200 million in false and fraudulent claims to private insurance companies including Cigna, Florida Blue, and United Healthcare on behalf of fraudulent clinics located in Florida, New Jersey, Nebraska, Kentucky, Texas, and other states. The investigation resulted in the arrest of four main targets, over 17 indictments from spin-off cases against clinic owners who utilized the billing companies, as well as court ordered restitution from each target.

UNITED STATES OF AMERICA V. RICHARD PAULUS

This investigation is noteworthy due to its unraveling of a corrupt area of practice in cardiology that has significant financial and personal impact to the victims. The investigation uncovered that there were multiple cases nationwide involving the rendering of medically unnecessary cardiac procedures such as stress tests, catheterizations, and stents. Kickback relationships between local cardiology practices and hospital-employed cardiologists resulted in a physician salary structure which incentivized overutilization and the performance of unnecessary procedures and tests. Paulus was sentenced to 60 months imprisonment and restitution of $1.1 million.

UNITED STATES OF AMERICA V. SANCHEZ ET AL.

Gilberto Sanchez, a doctor from Montgomery, Alabama, was charged with, and pleaded guilty to, charges that included health care fraud, conspiracy to distribute controlled substances, and money laundering. Among the drugs Dr. Sanchez unnecessarily prescribed were dangerous opioids, including oxycodone, hydrocodone, and fentanyl. Dr. Sanchez also gave out illegitimate prescriptions for amphetamines, including Adderall, and benzodiazepines, including Xanax. Sanchez was sentenced to over 12 years in federal prison and was ordered to pay $7.7 million in restitution.

UNITED STATES OF AMERICA V. PAUL L. SMITH

Paul L. Smith, PhD, a licensed psychologist had been under investigation for many years for billing for services not rendered. Smith was indicted in June 2018 on 13 counts of health care fraud and 5 counts of money laundering in the Eastern District of Michigan. On June 26, 2019, he pleaded guilty to one count of health care fraud and one count of money laundering. Smith agreed to $3.1 million in restitution. Smith also faced state sanctions and had his license suspended by the State of Michigan Department of Licensing and Regulatory Affairs.

UNITED STATES OF AMERICA V. USA HOME HEALTH CARE AGENCY, INC. ET AL.

An investigation revealed the owners of USA Home Health Care Agency, Inc. were engaged in schemes to enrich themselves by defrauding Medicare through their agency and other home health agencies. It was also alleged that the owners were furthering their schemes and concealing their illicitly gained fraudulent proceeds through numerous shell companies that purportedly provided healthcare-related and advertising services to the home health agencies. This investigation has led to the disruption and dismantling of the fraudulent network consisting of eight home health agencies, one comprehensive outpatient rehabilitation facility, and ten subjects responsible for the loss of nearly $85 million to Medicare.

UNITED STATES OF AMERICA V. VANGUARD HEALTHCARE ET AL.

This case involved substandard care of patients and the submission of fraudulent Patient Assessment Evaluation forms (PAE's) in order to qualify patients in Tennessee's Medicaid program, TennCare, and placed in eligible nursing homes. There was an organized effort across multiple facilities in the organization to provide forged PAE's to TennCare. These PAE's had signatures of physicians that had been forged and/or photocopied without the physicians' permission. By forging and submitting fraudulent PAE's, it allowed the nursing facilities to either admit or retain patients in the nursing homes, obviously resulting in payment they were not entitled to receive. In January 2019, Vanguard agreed to pay more than $18 million in allowed claims to resolve a lawsuit brought by the United States and the State of Tennessee against them for billing the Medicare and Medicaid programs for grossly substandard nursing home services.

Awards Related Sessions

HIGHMARK HEMOPHILIA SPECIALTY PHARMACY/EMPLOYER GROUP INVESTIGATION

Recipients of the NHCAA's 2019 SIRIS Investigation of the Year Award will discuss the investigative strategies, multi-organization cooperation, and case-building excellence that led to successful resolution of the investigation and the coveted NHCAA honor.

WEDNESDAY, OCTOBER 16, 2019
2:45 PM – 3:45 PM
Room 209

UNITED STATES OF AMERICA V. BEAUCHAMP ET AL.

Recipients of NHCAA's 2019 Investigation of the Year Award will discuss the investigative strategies, multi-organization cooperation, and case-building excellence that led to successful resolution of the case and the coveted NHCAA honor.

WEDNESDAY, OCTOBER 16, 2019
4:00 PM – 5:00 PM
Room 209

UNITED STATES OF AMERICA V. ESFORMES ET AL.

Recipients of NHCAA's 2019 Investigation of the Year Award will discuss the investigative strategies, multi-organization cooperation, and case-building excellence that led to successful resolution of the case and the coveted NHCAA honor.

FRIDAY, OCTOBER 18, 2019
9:00 AM – 11:00 AM
Room 205

Our Mission *is to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution, and prevention of health care fraud and abuse.*

1220 L Street, NW
Suite 600
Washington, DC 20005

Phone: 202.659.5955
Web: www.nhcaa.org