

Part III

Legal and Investigative Activities Related to Medicare and Medicaid

Contents

Investigative Outcomes-----	1
Advisory Opinions and Other Industry Guidance-----	3
Health Care Fraud Prevention and Enforcement Action Team Activities	3
HEAT Provider Compliance Training -----	3
Medicare Fraud Strike Force Activities -----	4
Other Criminal and Civil Enforcement Activities -----	6
Special Assistant United States Attorney Program-----	6
Most Wanted Fugitives Listed on OIG’s Web Site-----	6
Recently Completed Cases and Settlements -----	7
Pharmaceutical Companies-----	7
Prescription Drugs-----	8
Hospitals-----	9
Home Health Agencies-----	9
Hospice Care -----	10
Nursing Homes-----	10
Clinics-----	11
Practitioners and Other Suppliers -----	12
Durable Medical Equipment-----	12
Transportation Fraud-----	14
Private Citizens-----	14
Medicaid Fraud Control Units -----	15
Funding and Accomplishments-----	15
Joint Investigations -----	15

Sanction Authorities and Related Administrative Actions -----	16
Program Exclusions -----	17
Corporate Integrity Agreements -----	17
Civil Monetary Penalties Law -----	18
Patient Dumping -----	19
Provider Self-Disclosure Protocol -----	20

Part III

Legal and Investigative Activities Related to Medicare and Medicaid

Investigative Outcomes

For this semiannual period, we reported 346 criminal and 138 civil actions against individuals or entities that engaged in health-care-related offenses. We also reported \$610.9 million in Department of Health and Human Services (HHS) investigative receivables and 130.8 million in non-HHS investigative receivables (such as those from our work related to the States' shares of Medicaid restitution) for health-care-related offenses.

The Office of Inspector General's (OIG) investigations often involve the combined efforts and resources of our office and other Federal and State law enforcement agencies. One of the most common types of fraud perpetrated against Medicare, Medicaid, and other Federal health care programs involves filing false claims for reimbursement. False claims may be pursued under Federal and State criminal statutes and, in appropriate cases, under the False Claims Act Amendments of 1986 (FCA), as further amended in 2009.

Depending on the types of fraud or other violations involved, OIG's investigations may culminate in criminal or civil court judgments and decisions, administrative sanctions and decisions, and/or negotiated settlement agreements. Investigative outcomes take many forms, including incarceration, restitution, fines, penalties, forfeitures, assessments, and exclusion of individuals or entities from participation in all Federal health care programs. Frequently used exclusion and penalty authorities are described in Appendix D of this *Semiannual Report to Congress* and on our Web site at: <http://www.oig.hhs.gov/fraud/enforcement/cmp/index.asp>.

Investigative work often requires more than a year to yield results. As a consequence, many of the cases summarized in this section reflect the results of our Medicare- and Medicaid-related work over several years that culminated in the first half of fiscal year (FY) 2012.

The following charts show the investigative outcomes that OIG reported for all HHS programs over a 5-year period.

Chart 1 – Actions: All HHS Programs

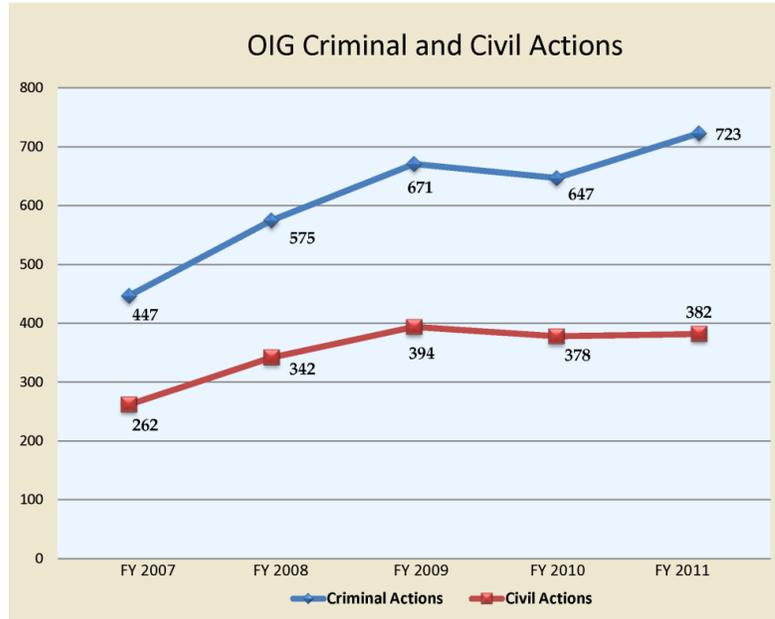
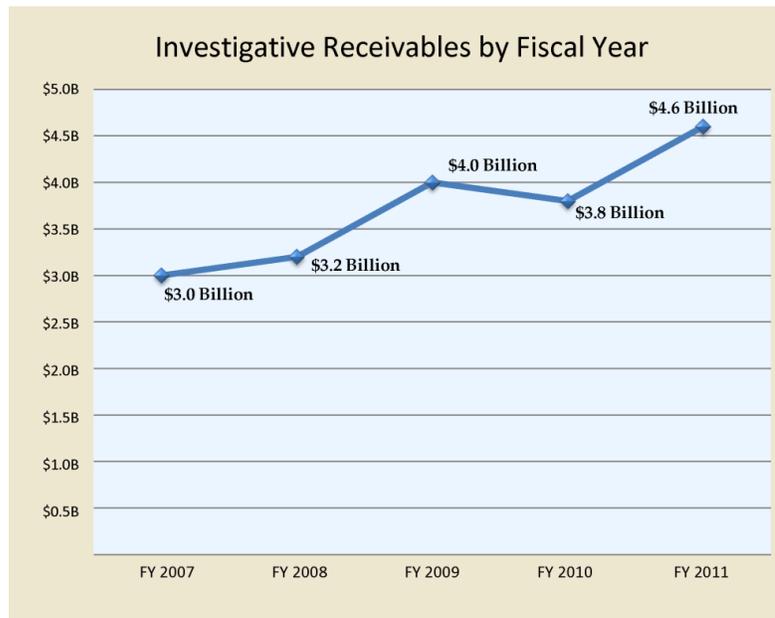


Chart 2 – Receivables: All HHS Programs

(Includes non-HHS receivables, e.g., States' share of Medicaid restitution.)



Advisory Opinions and Other Industry Guidance

As part of OIG's continuing efforts to promote the highest level of ethical and lawful conduct by the health care industry, we issue [advisory opinions](#) and [other guidance](#) to educate industry and other stakeholders on how to avoid fraud, waste, and abuse. Advisory opinions, which are developed in consultation with the Department of Justice (DOJ), are issued to requesting parties regarding the interpretation and applicability of certain statutes relating to Federal health care programs. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), § 205, allows OIG to provide case-specific formal guidance on the application of the anti-kickback statute and safe harbor provisions and other OIG health care fraud and abuse sanctions. During this period, we received 24 requests for advisory opinions. We issued eight new opinions, including one modification of an earlier opinion.

Health Care Fraud Prevention and Enforcement Action Team Activities

On May 20, 2009, HHS Secretary Kathleen Sebelius and Attorney General Eric Holder announced the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT), an interagency effort focused specifically on combating health care fraud. HEAT includes senior officials from DOJ and HHS who are strengthening programs, as well as investing in new resources and technologies, to prevent and combat fraud, waste, and abuse.

HEAT Provider Compliance Training

OIG provides free training on our Web site for health care providers, compliance professionals, and attorneys. OIG's Provider Compliance Training was an outreach initiative developed as part of HEAT. Following are links to various training resources:

- [Videos and Audio Podcasts](#)
- [Webcast](#)
- [Presentation Materials](#)

Medicare Fraud Strike Force Activities

The Medicare Fraud Strike Force is a key component of HEAT. The Strike Force began in March 2007 and is currently operating in nine cities—Miami, Florida; Los Angeles, California; Detroit, Michigan; Houston, Texas; Brooklyn, New York; Baton Rouge, Louisiana; Tampa, Florida; Chicago, Illinois; and Dallas, Texas. Strike Force teams coordinate joint law enforcement operations conducted by Federal, State, and local law enforcement entities.

These teams have a proven record of success in analyzing data to quickly identify fraud and prosecute the perpetrators. During this reporting period, Strike Force efforts have resulted in the filing of charges against 101 individuals or entities, 96 criminal actions, and \$50.9 million in investigative receivables.

(Correction to the Fall 2011 *Semiannual Report to Congress*: The number of Strike Force criminal actions for OIG for fiscal year 2011 was 181 instead of 184. The three cases were subsequently reassigned to other case categories.)

Strike-Force-Related Indictments, Arrests in Texas

In February 2012, the Medicare Fraud Strike Force attained another milestone with the indictment and arrest of a Texas physician and the office manager of his medical practice, along with five owners of home health agencies (HHA). The individuals were arrested on charges related to their alleged participation in a nearly \$375 million health care fraud scheme involving fraudulent claims for home health services—the single largest fraud orchestrated by one doctor in the history of HEAT and the Medicare Fraud Strike Force operation.

The indicted physician owned and operated an association of health care providers established to provide home health certifications and perform patient home visits. Between January 2006 and November 2011, the physician's association certified more Medicare beneficiaries for home health services and had more purported patients than any other medical practice in the United States.

The Government alleges that the physician and the involved HHAs certified patients that were not homebound and billed for more visits than occurred, resulting in more than \$350 million in fraudulent billing to Medicare and more than \$24 million in fraudulent billing to Medicaid. In addition, the Centers for Medicare & Medicaid Services (CMS) announced the suspension of 78 associated HHAs based on credible allegations of fraud. The indicted physician is awaiting trial.

Additional Examples of Strike Force Efforts

- **Michigan** – Two of OIG’s Top 10 most wanted fugitives, **Clara Guilarte** and **Caridad Guilarte** were each sentenced to 14 years of incarceration and ordered to pay over \$6 million in restitution, jointly and severally, after they pleaded guilty to charges related to a health care fraud and money laundering scheme. The pair owned and operated the **Dearborn Medical Rehabilitation Center** (DMRC), which purported to provide infusion and injection therapy to human immunodeficiency virus (HIV)-positive patients.

According to court documents, between November 2005 and March 2007, the Guilartes recruited and paid kickbacks to Medicare beneficiaries and billed Medicare for services not provided, while purchasing only a fraction of the medications billed to Medicare. The pair then distributed the proceeds through a series of transactions involving shell corporations that served no purpose other than to conceal the nature, source, and location of the funds.

The Guilartes, who fled the United States to avoid being apprehended, were arrested on March 14, 2011, by the Colombian National Police and transferred to the custody of U.S. officials.

- **Florida** – **Lisandra Alonso**, an office administrator, was sentenced to 78 months of incarceration after she pleaded guilty to charges of conspiracy to commit health care fraud. In addition, Alonso and co-conspirators **Farah Perez** and **Jose Ros** were ordered to pay \$15.3 million, \$118,000, and \$395,000, respectively, in restitution, jointly and severally, for their roles in the fraud scheme.

The trio was affiliated with **ABC Home Health, Inc.** (ABC), and Florida Home Health Care Providers, Inc., companies that purported to provide home health and physical therapy services to Medicare beneficiaries.

According to court documents, these companies existed for the purpose of defrauding Medicare. ABC fraudulently billed Medicare for home health services provided to beneficiaries who were not restricted to their homes and who had no medical necessity for the services. The scheme also entailed submitting false nursing notes for services not rendered and receiving money for recruited patients.

- **Michigan** – **Santiago Villa-Restrepo** was sentenced to 30 months of incarceration and ordered to pay restitution in the amount of \$2.9 million, jointly and severally, for his participation in a multimillion-dollar scheme to defraud Medicare. Villa-Restrepo and his

co-conspirators operated three purported medical clinics, **Blessed, Alpha & Omega**, and **Manuel**, all opened for the sole purpose of defrauding Medicare.

According to court documents, beginning approximately in 2007, Villa-Restrepo paid Medicare patients to undergo medically unnecessary diagnostic tests at the three clinics. In exchange for illegal kickbacks, the Medicare beneficiaries signed documents indicating they had received the services billed to Medicare.

The clinics involved in the fraud scheme subsequently billed Medicare for expensive and medically unnecessary diagnostic tests and diverted the proceeds to the clinic owners and co-conspirators for their personal use. Villa-Restrepo's co-conspirators are awaiting sentencing for their roles in the scheme.

Other Criminal and Civil Enforcement Activities

Special Assistant United States Attorney Program

During this reporting period, DOJ and OIG continued their participation in a program in which OIG attorneys, some of which are Special Agents, serve as Special Assistant United States Attorneys. OIG attorneys are detailed full time to DOJ's Criminal Division, Fraud Section, for temporary assignments, such as assignments to the Medicare Fraud Strike Force described above. Other attorneys prosecute matters on a case-by-case basis. Both arrangements offer excellent litigation training for OIG attorneys and enhance collaboration between the Departments in their efforts to fight fraud. Under this program, OIG attorneys have successfully litigated important criminal cases relating to durable medical equipment (DME), infusion therapy, physical therapy, and other types of Medicare and Medicaid fraud.

Most Wanted Fugitives Listed on OIG's Web Site

During the last FY, OIG launched the Most Wanted Fugitives list on its Web site. The list is continuously updated and involves the public in helping to capture fugitives charged with defrauding Federal health care programs and taxpayers of millions of dollars. The list features a photograph, a profile, and statistics for each fugitive, as well as an online tip form and a hotline number for individuals to report fugitive-related information to OIG in either English

or Spanish, 24 hours a day, 365 days a year. The Most Wanted Fugitives list is accessed at <http://oig.hhs.gov/fraud/fugitives/>.

In addition to captures during this semiannual period with the help of third-party visitors to our Web site, one fugitive contacted OIG after seeing himself on the online list. The Government alleges that between July 2003 and March 2007, the fugitive and his accomplices committed health care fraud by paying Medicare beneficiaries to sign Medicare reimbursement forms and by paying doctors and therapists to sign fictitious files for treatment and services that were never rendered; they then submitted the fraudulent claims to Medicare.

Recently Completed Cases and Settlements

The following represent various types of cases concluded during this semiannual period. Summaries are organized by the sector of the health care industry involved or by the nature of the offense.

Pharmaceutical Companies

- **California – Scios, Inc.** (Scios), a subsidiary of the pharmaceutical company Johnson & Johnson, pleaded guilty to a violation of the Food, Drug, and Cosmetic Act of 1938 (FDCA) and agreed to pay a criminal fine in the amount of \$85 million. Scios, based in Fremont, California, introduced its heart failure drug, Natrecor, into interstate commerce for a use not approved by the Food and Drug Administration (FDA). The FDA approved Natrecor for the treatment of acutely decompensated congestive heart failure with dyspnea (shortness of breath) at rest or with minimal activity. The approved labeling for Natrecor did not list any other use, and the drug was not approved by FDA for any other use. Scios admitted that it intended Natrecor to be used off-label for infusing chronic (nonacute) congestive heart failure patients on a scheduled, serial basis, even though the company understood that this was not an approved use of the drug. Scios also admitted the FDA-approved labeling for Natrecor did not contain any directions for this scheduled, serial use to treat chronic patients.
- **Michigan – GE Healthcare, Inc.** (GEHC), agreed to pay \$30 million plus interest to resolve allegations that an acquired entity previously known as **Amersham Health, Inc.** (Amersham), violated the FCA. Specifically, the Government alleged that Amersham knowingly provided false or

misleading information to CMS and its contractors from January 2000 through December 2003 regarding Myoview, a radiopharmaceutical product used in certain cardiac diagnostic imaging procedures. The Government contended that the false and misleading information Amersham provided caused the Medicare program to reimburse certain claims for Myoview at artificially inflated rates.

- **Pennsylvania** – Four individuals each pleaded guilty, as responsible corporate officers, to one misdemeanor count of shipping an adulterated and misbranded medical device in interstate commerce. **Michael D. Huggins**, former President of Synthes North America, a subsidiary of **Synthes, Inc.** (Synthes); **Thomas B. Higgins**, former President of Synthes’s Spine Division; **Richard E. Bohner**, former Vice-President of Operations for Synthes, and **John J. Walsh**, former Director of Regulatory and Clinical Affairs for Synthes’s Spine Division, participated in the criminal conduct. Huggins was sentenced to 9 months of incarceration; Higgins was sentenced to 9 months of incarceration; Bohner was sentenced to 8 months of incarceration; and Walsh was sentenced to 5 months of incarceration.

In connection with this case, associated companies, Synthes and its former subsidiary, **Norian Corporation** (Norian), which develop, manufacture, distribute, market, and sell medical devices, entered into a global resolution with the United States to resolve liability with respect to allegations of conducting unauthorized clinical trials of Synthes’ medical devices, Norian XR and Norian SRS. The devices were allegedly used in surgeries to treat vertebral compression fractures of the spine, a painful condition commonly suffered by elderly individuals.

Many of these procedures were performed on Medicare and other Federal health care program beneficiaries, and the procedures were conducted despite a warning on the label for Norian XR against this use and despite serious medical concerns about the safety of the devices when used in the spine.

Prescription Drugs

- **Indiana – John Love**, controlling member and pharmacist for the **Terre Haute Prescription Shop** (THPS), was sentenced to 4 years and 3 months of incarceration and ordered to pay \$3.5 million in restitution for his role in a health care fraud and money laundering scheme. Between January 2006 and September 2010, Love used his position at the pharmacy to carry out a scheme to defraud the Indiana Medicaid Program. Love

entered false prescriptions in the THPS computer billing system which, in turn, billed the Indiana Medicaid Program.

- **Massachusetts – Ernest Melvin McGee**, assistant pharmacist of **Codman Square Pharmacy** (Codman), along with Codman’s owner, **Amadiogwu Onujiogu**, solicited paper prescriptions from customers in exchange for illegal kickbacks and submitted false claims to Medicare and Medicaid. McGee and Onujiogu targeted customers with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and/or psychiatric disorders, such as depression and bipolar disorder—conditions that require expensive prescriptions. Many of the beneficiaries they recruited were drug addicts or homeless persons. McGee was sentenced to 12 months and 1 day of incarceration and was ordered to pay restitution in the amount of \$292,635 and \$60,037 to Medicaid and Medicare, respectively, for his role in the health care fraud scheme. Onujiogu was previously convicted on the same charge and sentenced to 15 months of incarceration.
- **Florida – Paul Wagner Jr.**, a private citizen, was sentenced to 7 years and 2 months of incarceration for possession with intent to distribute, as well as for distributing the Schedule II drug Oxycodone. Wagner was part of a fraud scheme that entailed obtaining paper Oxycodone prescriptions from a local physician who prescribed the controlled substances to Medicare and Medicaid beneficiaries, despite lack of medical necessity. Wagner then assisted in filling the prescriptions and trafficking the drugs to street dealers.

Hospitals

Georgia – Satilla Health Services, Inc., d/b/a **Satilla Regional Medical Center** (Satilla) agreed to pay \$840,000 to resolve its liability under the FCA. The agreement resolves allegations that Satilla submitted claims to Medicare and Medicaid for medically unnecessary and dangerous endovascular procedures performed by a physician for the medical center’s heart center that caused serious injury to 37 patients. In addition, Satilla has entered into an agreement with another company to purchase Satilla, which will result in a new board of directors, new administrators, and a new compliance program at Satilla.

Home Health Agencies

Virginia – Health Care of Virginia, LLC. (HCV), an HHA, was ordered to pay \$323,420 in restitution for health care fraud. The company allegedly

submitted claims to the Virginia Medicaid program for services rendered by untrained personal care aides. The investigation indicated that HCV falsified training certificates and patient assessments. Two other defendants pleaded guilty for their roles in the fraud scheme and have been sentenced.

Hospice Care

- **Wisconsin - Odyssey Healthcare, Inc.** (Odyssey), a subsidiary of Gentiva Health Services, Inc., agreed to pay \$25 million to resolve allegations that between January 2006 and January 2009, Odyssey submitted claims for hospice services that were medically unnecessary. The investigation found Odyssey billed Medicare for continuous or crisis care services when the patients were not experiencing a crisis. Continuous or crisis care is reimbursed by Medicare at a higher rate than routine care. As part of the settlement, Odyssey entered into a 5-year corporate integrity agreement (CIA) with OIG.
- **Arkansas – Hospice Home Care, Inc.** (HHC), agreed to pay \$2.7 million to resolve its liability under the FCA for allegedly submitting false claims to Medicare. Between January 2002 and December 2004, HHC allegedly billed Medicare for general inpatient services when the patients received only routine care, which has a lower reimbursement rate.

Nursing Homes

Tennessee – Vanguard Healthcare Ancillary Services, LLC; Vanguard Healthcare, LLC; and Vanguard Healthcare Services, LLC (collectively, Vanguard), agreed to pay \$2 million as a part of a settlement agreement to resolve allegations of false claims and illegal kickbacks. Between March 1998 and September 2008, Vanguard allegedly submitted claims to Medicare for enteral (nutrition) therapy goods and services that were also billed to the Tennessee and Mississippi Medicaid programs.

Vanguard allegedly failed to disclose the relationship between its long-term-care (LTC) facilities (which billed Tennessee and Mississippi Medicaid for the enteral therapy goods and services) and Vanguard Healthcare Ancillary Services (which billed Medicare Part B for the same enteral therapy goods and services). Vanguard also allegedly submitted claims to Medicare for certain free items, namely pumps used to deliver nutritional products and intravenous poles used in the administration of enteral therapy that Vanguard had received at no cost from a third party supplier in order to induce referrals.

Clinics

- **Texas – Umawa Oke Imo**, owner and operator of **City Nursing Services of Texas Inc.** (City Nursing Services), and his co-conspirators, fraudulently used City Nursing Services to pay kickbacks to Medicare beneficiaries and recruiters; provide physical therapy services to Medicare beneficiaries even though it did not employ any licensed or qualified physical therapists; and bill Medicare for physical therapy services that were not rendered. To mask this practice, City Nursing Services created false and fraudulent patient files.

Imo was sentenced to 27 years and 3 months of incarceration and ordered to pay more than \$30.2 million in restitution, jointly and severally, after being convicted on charges of conspiracy to commit health care fraud, health care fraud, and aiding and abetting.

Co-conspirators **Joanne White** and **Christina Joy Clardy** were also sentenced in the scheme. White was sentenced to 3 years and 10 months of incarceration and ordered to pay more than \$25.5 million in restitution, jointly and severally. Clardy was sentenced to 11 years and 3 months of incarceration and ordered to pay more than \$15.6 million in restitution, jointly and severally. Other conspirators were indicted.

- **New Jersey –The Center for Lymphatic Disorders**, LLC (CLD), was ordered to pay \$3 million in restitution as a result of a guilty plea to third-degree health care claims fraud by office manager **Farah Houtan**. Between January 2004 and June 2007, Houtan billed Medicare and Medicaid for services not provided to patients. CLD staff allegedly submitted claims for surgical procedures but, in fact, provided physical therapy services, which has a lower reimbursement rate.
- **Nevada – Dennis Falls**, former owner and sole practitioner for **Nevada Pulmonary and Sleep Diagnostics** (NPSD), was sentenced to 2 years and 3 months of incarceration and ordered to pay \$226,539 in restitution after he pleaded guilty to health care fraud. Falls caused claims to be submitted to Medicare for sleep studies and pulmonary stress tests that were neither requested by referring physicians nor performed. The investigation revealed that more than 50 percent of NPSD's sleep studies were conducted at the homes of beneficiaries, which is not covered by Medicare, but were billed as though they were performed in the office.
- **California – North Valley Radiation Oncology Medical Group** (NVRONG), a medical practice that provides oncology services to patients in northern California, agreed to pay \$46,220 to resolve its liability under the FCA for

submitting false claims to Medicare. Between January 2003 and February 2010, NVRONG allegedly billed Medicare for radiation services improperly coded with the place of service as their physician offices, when in fact the services were provided on the premises of a hospital's clinic. Medicare pays physicians a higher reimbursement for certain categories of services that are provided at their offices rather than in a hospital setting.

Practitioners and Other Suppliers

- **Michigan – Gwendolyn Washington**, a family practice physician, was sentenced to 10 years of incarceration and ordered to pay \$5.4 million in restitution for receiving kickbacks and fraudulently billing for diagnostic tests and services that were not medically necessary. During the investigation, CMS placed Washington on a prepayment review, which upon evaluation, resulted in a suspension of Washington's Medicare payments.
- **Maryland – Larry Bernhard**, a Maryland podiatrist, was sentenced to 4 years and 6 months of incarceration and ordered to pay \$1.1 million in restitution for his scheme to defraud Medicare Advantage (Part C) plans. Bernhard pleaded guilty to fraudulently billing Medicare for services to patients he had never seen. Additionally, Bernhard used the names and other personally identifiable information of approximately 200 nursing home patients to submit false claims for podiatry care he never provided.

Durable Medical Equipment

- **Minnesota – Medtronic, Inc.**, a DME manufacturer, agreed to pay \$23.8 million plus interest to resolve allegations that it violated the FCA. The Government alleged that Medtronic used postmarket studies and device registries as vehicles to pay physicians illegal kickbacks to induce them to implant Medtronic pacemakers and defibrillators. It was also alleged that Medtronic solicited physicians for the studies and registries to convert their business from a competitor's product and persuade physicians to continue using Medtronic products.
- **California – Christopher Iruke**, owner and operator of several fraudulent DME companies; his wife and co-conspirator **Connie Ikpoh**; and co-conspirators **Aura Marroquin** and others used fraudulent prescriptions and documents to bill Medicare for expensive high-end power wheelchairs and orthotics that were medically unnecessary or were

never provided. Iruke and Ikpoh diverted most of the proceeds from their scheme to pay for business and personal expenses, including the leases on their Mercedes vehicles and home-remodeling expenses. Iruke was sentenced to 15 years of incarceration and ordered to pay \$6.7 million in restitution, jointly and severally with co-conspirators, for his role in the multimillion-dollar scheme. Iruke's sentence is one of the longest health care fraud sentences ever imposed in the Central District of California. Ikpoh, Marroquin, and two other co-conspirators were also convicted for their roles in the scheme.

- **Texas – James Reese, Lia St. Junius, Brenda Lopez, Lily Johnson**, and others of **The Mobility Store** (TMS), a DME company, took part in a scheme that fraudulently billed braces to Medicare and Medicaid as orthotic devices. As a result, Medicare reimbursed TMS at a rate many times the actual cost of the braces. Reese, Junius, Lopez, and Johnson were sentenced to 15 years, 11 years and 3 months, 3 years and 7 months, and 2 years and 9 months of incarceration, respectively, for their roles in the scheme. Additionally, Johnson was ordered to pay \$4 million in restitution, jointly and severally, and Lopez, Reese, and St. Junius were each ordered to pay \$8.6 million, jointly and severally.
- **Florida – Benjamin Bane** (B. Bane), owner and operator of two DME companies that provided oxygen therapy in central and west Florida, and two associated managers, **Greg Bane** (G. Bane) and **Tracy Bane** (T. Bane), were sentenced to incarceration and ordered to pay restitution for participating in a scheme to defraud Medicare and Medicaid.

Although DME companies are expressly prohibited by Medicare regulations from performing the qualifying tests to establish medical necessity for home oxygen, B. Bane allegedly instructed his employees to perform such tests; falsify test results; and alter information on office computers, such as the beneficiary's name and the procedure date. The qualifying test results were then provided to either one of two pulmonary diagnostics companies to appear as though they had been performed by an independent diagnostic testing facility in accordance with Medicare regulations and were therefore eligible for reimbursement.

B. Bane was sentenced to 12 years of incarceration and ordered to pay \$7 million in restitution, jointly and severally. G. Bane and T. Bane were sentenced to 3 years and 6 months of incarceration for their roles in the scheme, respectively, and both were ordered to pay \$7 million, jointly and severally, in restitution.

California – Mariya Bagdasaryan, owner of **Goldberg Medical Supply**, was sentenced to 3 years and 1 month of incarceration and ordered to pay \$576,803 in restitution for one count of health care fraud. Between October 2007 and December 2008, Bagdasaryan defrauded the Medicare and Medi-Cal programs by paying kickbacks to marketers to solicit beneficiary information with promises of free DME. Bagdasaryan then sold the beneficiary information to a Medicare billing service, which, in turn, sold some of the information to a fraudulent DME company called **True Care Medical Supply** (True Care). True Care then submitted claims to Medicare falsely representing that it had supplied DME to the Medicare beneficiaries.

Bagdasaryan received the longest possible prison term partly because of a conviction in 2002 for the same offense. In January 2011, the True Care owner, **Edgar Srapyan**, was sentenced to 37 months of incarceration and ordered to pay over \$330,000 in restitution.

Transportation Fraud

Rhode Island – John Almon, president and owner of **Med Care Ambulance LLC** (Med Care), was sentenced to 2 years of incarceration and ordered to pay \$704,117 in restitution for health care fraud. Between March and December 2008, Almon submitted fraudulent claims to Medicare and Blue Cross and Blue Shield by billing routine dialysis transports as specialty care transports (SCT), even though Med Care did not have the proper equipment or personnel to provide SCTs. This upcoded billing, which should have been billed as basic life support, resulted in a higher reimbursement rate. Almon also instructed his employees to alter the trip sheets to ensure that the transports qualified as SCTs.

Private Citizens

Florida – Joel Martinez-Hernandez, Eliezer Lazo, and Emilio Bezanilla were sentenced to 7 years, 5 years and 3 months, and 3 years and 1 month of incarceration, respectively. Between December 2007 and February 2008, Martinez-Hernandez, along with co-conspirators Lazo, Bezanilla, and others, laundered fraudulent proceeds from five pharmacies and DME companies. Martinez-Hernandez was charged with 15 counts of money laundering and 2 counts of structuring to avoid reporting requirements and was ordered to pay \$250,000 in restitution following his jury trial conviction. After the convictions of these individuals and with cooperation from other defendants, the owner of the pharmacies and DME companies was indicted for

allegations of crimes, including health care fraud and aggravated identity theft.

Medicaid Fraud Control Units

Funding and Accomplishments

Medicaid Fraud Control Units (MFCU) are key partners in the fight against fraud, waste, and abuse in State Medicaid programs. In FY 2011, HHS awarded \$156.7 million in Federal grant funds to 50 MFCUs (including 1 in Washington, DC), which employed a total of 1,833 individuals. Collectively, in FY 2011, MFCUs reported 14,819 investigations, of which 10,685 were related to Medicaid fraud and 4,134 were related to patient abuse and neglect, including misappropriation of patients' private funds. The cases resulted in criminal charges against or indictments of 1,408 individuals, including 1,011 for fraud and 397 for patient abuse and neglect, including patient funds cases. In total, 1,230 convictions were reported in FY 2011, of which 824 were related to Medicaid fraud and 406 were related to patient abuse and neglect, including patient funds cases.

Joint Investigations

- **Minnesota – John Alemoh Momoh**, owner and operator of **Hopecare Service, Inc.** (Hopecare), was sentenced to 2 years of incarceration and ordered to pay \$656,876 in restitution to Medicaid for claims submitted for personal care assistant (PCA) services. Between May 2007 and March 2008, Momoh submitted false claims with respect to the number of PCA service hours provided to Medicaid beneficiaries. Momoh also submitted false claims to Medicaid for services that were not rendered, were provided by an unqualified individual, and were not medically necessary.
- **Pennsylvania – Octavia Durham** (Durham) and her daughter, **Anneikkia Durham Smith** (Smith), were sentenced for their roles in a Medicaid fraud scheme. A relative of the pair who was a Medicaid beneficiary received attendant care services from Durham pursuant to the Medicaid Commerce Waiver Program.

An initial investigation by the Pennsylvania MFCU revealed that the beneficiary suffered from ulcers, bed sores, dehydration, and malnutrition and had missed numerous medical appointments.

A doctor who examined him in June 2009 recommended that the beneficiary be immediately transported to an emergency room. On a number of Durham's attendant timesheets, Smith signed on behalf of the beneficiary, verifying Durham's hours and services provided. Numerous timesheets and claims submitted to Medicaid included hours that Durham allegedly provided care when in fact Durham was employed elsewhere or was out of town or when the beneficiary was hospitalized or was in a nursing home.

Durham was sentenced to between 11½ months to 23 months of incarceration and ordered to pay \$128,000 in restitution. Smith was ordered to pay \$38,614 of this amount, jointly and severally with Durham and was sentenced to a 7-year term of probation. This was a joint investigation with the MFCU of the Pennsylvania Attorney General's Office and the Montgomery County District Attorney's Office.

Sanction Authorities and Related Administrative Actions

Various Federal laws provide authorities to impose administrative sanctions for fraud and abuse as well as other activities that pose a risk to Federal health care programs and their beneficiaries. (See Appendix D for a summary of frequently used sanction authorities.)

Sanctions include the exclusion of individuals and entities from Federal health care programs and the imposition of civil monetary penalties (CMP) for submitting false and fraudulent claims to a Federal health care program or for violating the anti-kickback statute; the Stark Law; or the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), also known as the anti-patient-dumping law.

During this reporting period, OIG administered 1,304 sanctions in the form of program exclusions or administrative actions for alleged fraud or abuse or other activities that posed a risk to Federal health care programs and their beneficiaries. OIG is also responsible for reinstating providers who apply and have met the requirements of their exclusions. Exclusion and penalty authorities are described in Appendix D and on our Web site at: <http://www.oig.hhs.gov/fraud/enforcement/cmp/index.asp>.

Program Exclusions

During this semiannual reporting period, OIG excluded 1,264 individuals and entities from Medicare, Medicaid, and other Federal health care programs.

Most of the exclusions resulted from convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of license revocation. For a list of excluded individuals and entities, see

<http://exclusions.oig.hhs.gov/>.

For example:

- **Iowa – Kenneth Brown**, who was a certified medication aide at a residential facility, was excluded for 20 years for his conviction on two counts of dependent adult abuse. He sexually exploited two dependent adults and caused them to suffer mental injuries and increased symptoms regarding their mental health problems. Mr. Brown also has a prior criminal history that includes convictions for driving with a suspended license; assault with intent to cause pain or injury; theft in the fifth degree; driving while barred – habitual offender; and possession of a controlled substance. Additionally, the Iowa Director Care Worker Registry placed a finding of abuse on its registry regarding Brown.
- **Florida – Reinaldo Guerra**, the owner of durable medical equipment companies, was excluded for 95 years on the basis of his conviction of health care fraud and conspiracy to commit health care fraud. From 2002 to about August 2004, Guerra and his conspirators submitted false and fraudulent Medicare claims on behalf of the companies seeking reimbursement for DME that was neither ordered by a physician nor provided to the beneficiary. The court ordered Guerra to pay \$35.1 million in restitution and to serve 168 months of incarceration.
- **Ohio – Robert Scott Blankenburg**, a pediatrician, was excluded for 50 years on the basis of his conviction of unlawful sexual conduct with a minor, bribery, complicity to deception to obtain dangerous drugs, and compelling prostitution. From about March 1992 to about December 2008, Blankenburg provided prescriptions for controlled substances or money to patients in return for sexual favors. The court sentenced him to 13 years of incarceration. The Ohio State Board of Medicine permanently revoked his license to practice medicine.

Corporate Integrity Agreements

OIG assists DOJ in bringing and settling cases under the FCA. Many providers elect to settle their cases prior to litigation. As part of their

settlements, providers often agree to enter into CIAs with OIG to avoid exclusions from Medicare, Medicaid, and other Federal health care programs. Such agreements are monitored by OIG and require the providers to enhance existing compliance programs or establish new ones. The compliance programs are designed, in part, to prevent a recurrence of the underlying fraudulent conduct. During this period, 14 CIAs were executed. [More information on CIAs](#) is available on our Web site.

Example of CIA Violation – On November 23 and December 30, 2011, OIG imposed penalties totaling \$57,500 on **The SCOOTER Store, Inc.** (SCOOTER Store), for failure to submit timely reports, as required under its CIA. On February 17, 2012, OIG sent a Notice of Material Breach and Intent to Exclude the SCOOTER Store based on its failure to repay an identified overpayment.

Civil Monetary Penalties Law

The Civil Monetary Penalties Law (CMPL) authorizes OIG to impose administrative penalties and assessments against a person who, among other things, submits, or causes to be submitted, claims to a Federal health care program that the person knows or should know are false or fraudulent. During this reporting period, OIG concluded cases involving more than \$6.1 million in CMPs and assessments. The following are among the CMP actions resolved during this reporting period:

- **New Jersey – Sandoz Inc.** (Sandoz), a pharmaceutical manufacturer, agreed to pay \$230,000 to resolve its potential liability under the CMPL. Specifically, the Government contended that Sandoz failed to timely submit pricing data required under the Medicaid Drug Rebate Program.
- **Iowa – Buchanan County Health Center** (BCHC), a primary care community hospital, agreed to pay \$406,030 to resolve its potential liability under the CMPL for employing an excluded individual from 2007 to May 2011. The individual's exclusion was based on a conviction relating to a controlled substance violation. The Government contended that BCHC knew or should have known that the individual was excluded.
- **Mississippi** – OIG reached settlements with eight physicians who violated the CMPL by causing the submission of false claims to Medicare from physical medicine companies. Specifically, the physicians reassigned their Medicare payments to various physical medicine companies in exchange for medical directorship positions. The physicians did not personally render or directly supervise any physical therapy or related health care services.

As a result, unlicensed individuals with little or no medical background provided unsupervised in-home physical therapy services to Medicare beneficiaries. The physical medicine companies falsely billed Medicare using the physicians' reassigned provider numbers as if the physicians had personally rendered the services or directly supervised individuals rendering the services.

The eight physicians have collectively paid \$604,874 to resolve their CMPL liability. These administrative CMPL cases were collateral investigations associated with criminal cases prosecuted by the U.S. Attorney's Office for the Southern District of Mississippi. Several owners and operators of the physical medicine companies were criminally prosecuted in Federal court for their roles in these schemes.

Patient Dumping

Some of the CMPL cases that OIG resolved between October 1, 2011, and March 31, 2012, were pursued under EMTALA, a statute designed to ensure patient access to appropriate emergency medical services. The following are examples of settlements under this statute:

- **Alabama – Princeton Baptist Medical Center** (Princeton Baptist) agreed to pay \$170,000 to resolve its potential liability under EMTALA. The Government alleged that Princeton Baptist failed to provide neurosurgical care, within its capabilities, to four individuals suffering from unstable emergency medical conditions.
- **Georgia – Piedmont Hospital** (Piedmont) agreed to pay \$50,000 to resolve its potential liability under EMTALA. The Government alleged that Piedmont failed to provide an appropriate medical screening exam and stabilizing treatment for an individual who presented to Piedmont's Emergency Department for evaluation and treatment of an emergency medical condition. The individual made repeated requests for treatment for approximately 8 hours without success. The individual left Piedmont, went to another hospital, and was diagnosed and treated for deep vein thrombosis and pulmonary embolus.
- **Tennessee – Vanderbilt University Medical Center** (Vanderbilt) agreed to pay \$45,000 to resolve its potential liability under EMTALA. The Government alleged that Vanderbilt refused to accept the appropriate transfer of a 66-year-old patient suffering from a large subdural hematoma on the brain with a midline shift. The patient had an unstable emergency medical condition that required the specialized capabilities available at Vanderbilt. Matthew Pearson, M.D., the neurosurgeon on call

at Vanderbilt, agreed to pay \$35,000 to resolve his potential liability as a responsible physician under EMTALA for refusing to accept an appropriate transfer of an individual with an unstable emergency medical condition that required the services of a neurosurgeon. The patient died a few hours later at another hospital.

Provider Self-Disclosure Protocol

OIG is committed to assisting health care providers and suppliers in detecting and preventing fraud and abuse. Since 1998, we have made available comprehensive guidelines describing the process for providers to voluntarily submit to OIG self-disclosures of fraud, waste, or abuse. The Provider Self-Disclosure Protocol gives providers an opportunity to minimize the potential costs and disruption that a full-scale OIG audit or investigation might entail if fraud is uncovered. In doing so, the self-disclosure also enables the provider to negotiate a fair monetary settlement and potentially avoid being excluded from participation in Federal health care programs.

The protocol guides providers and suppliers through the process of structuring a disclosure to OIG about matters that constitute potential violations of Federal laws (as opposed to honest mistakes that may have resulted in overpayments).

After making an initial disclosure, the provider or supplier is expected to thoroughly investigate the nature and cause of the matters uncovered and make a reliable assessment of their economic impact (e.g., an estimate of the losses to Federal health care programs). OIG evaluates the reported results of each internal investigation to determine the appropriate course of action.

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

During this reporting period, self-disclosure cases resulted in \$15.4 million in HHS receivables. The following are examples:

- **Illinois – Resurrection Health Care, Inc.** (Resurrection), agreed to pay \$2.8 million to resolve its potential liability under the CMPL. Resurrection voluntarily disclosed multiple personal service and lease arrangements, which created potential liability under the Physician Self-Referral Law (Stark Law) and the anti-kickback statute, along with three arrangements with excluded individuals. Resurrection disclosed the conduct through the Self-Disclosure Protocol.

- **New York – New York City Health and Hospitals Corporation (HHC)** agreed to pay \$442,909 to resolve HHC’s potential liability under the CMPL for employing excluded individuals. HHC disclosed that it employed eight excluded individuals from August 1999 through October 2010. HHC voluntarily disclosed the conduct through the Self-Disclosure Protocol.
- **Wisconsin – Westfields Hospital (Westfields)** agreed to pay \$204,150 to resolve its potential liability under the CMPL for violating the anti-kickback statute. Westfields voluntarily disclosed the provision of space, services, and supplies to certain physician group practices without entering into a formal written contract and without collecting payment. Westfields disclosed the conduct through the Self-Disclosure Protocol.
- **West Virginia – West Virginia University Hospitals - East, Inc.; City Hospital, Inc.; and The Charles Town General Hospital d/b/a Jefferson Memorial Hospital** (collectively the hospitals) agreed to pay \$949,595 to resolve their potential CMPL liability for violating the Anti-Kickback Statute. Specifically, the hospitals voluntarily disclosed that they failed to collect rental payments under physician arrangements, paid costs and expenses pursuant to recruitment agreements in excess of actual additional incremental costs, paid student loans without written recruitment agreements, and paid costs and expenses pursuant to unwritten extensions of recruitment agreements. The hospitals voluntarily disclosed the conduct through the Self-Disclosure Protocol.