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March 1, 2005

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PRESS RELEASE

UNITED STATES AND STATE OF OREGON ANNOUNCE JOINT EFFORT TO COMBAT HEALTH CARE FRAUD AND KICKBACKS

4 FELONY GUILTY PLEAS, OTHER FELONY CHARGES ANNOUNCED OVER $2.4 MILLION IN RESTITUTION AND DAMAGES OBTAINED SO FAR

UNITED STATES ATTORNEY KARIN J. IMMERGUT and OREGON ATTORNEY GENERAL HARDY MYERS today announced the filing of charges against five defendants for participation in a variety of health care fraud and kickback schemes. Four of the defendants have pled guilty and are awaiting sentencing; a fifth is awaiting trial.

"Health care fraud cheats Oregonians of their tax dollars and makes it harder for health care programs to provide care to those truly in need," Ms. Immergut said. "And at a time when health care costs are skyrocketing, we need to redouble our efforts to prosecute those who engage in health care fraud."

"Especially when budgets are tight, it is imperative that we crack down on fraudulent schemes," Attorney General Myers agreed.

Ms. Immergut and Attorney General Myers were joined by representatives from the lead investigative agencies in the cases, including Special Agent-In-Charge Sarah Allen of the Office of the Inspector General for the Department of Health and Human Services, Resident Agent-In-Charge Jennifer Wallace of the Department of Defense Criminal Investigative Service, and Supervisory Special Agent Scott Jensen of the Federal Bureau of Investigation.

The five cases stem from investigations undertaken as part of a joint state-federal effort to crackdown on health care fraud in Oregon. These investigations focused on three unrelated businesses that represent a cross-section of the health care industry: **Family Medical Management Services, Inc.**, which operated a chain of health clinics in Oregon and Washington, **West Coast Medical Supply Corp.**, a Portland supplier of durable medical equipment, and Bay Area Foot

Clinic, the podiatry clinic owned by defendant **William A. Bennett**[1], located in North Bend, Oregon.

The charges include payment of kickbacks, health care fraud, and making false statements in connection with a health plan. (A summary of the three cases and results achieved thus far, drawn from publicly available documents, is attached.)

Overall, the investigations resulted in two persons and two corporations pleading guilty to felony charges, and the filing of felony charges against another person. The defendants include the Administrative Officer of **Family Medical Management Services**, a chain of health care clinics, the President of **West Coast Medical Supply LLC**, a medical supply corporation, and a podiatrist, **William A. Bennett**. A second doctor, who was not prosecuted criminally – the Medical Director of **Family Medical Management Services**' chain of health clinics – forfeited the right to see patients of federal health plans until 2010.

Simultaneously with the four criminal pleas, the defendants entered into civil agreements providing for payment of double damages to the United States under the civil False Claims Act totaling in excess of $2.4 million. In addition to the civil damages agreed to, the defendants face various criminal sentences.

The **West Coast Medical Supply** and **Family Medical Management Services** cases are being prosecuted by Assistant United States Attorney Dwight C. Holton. For further information, you may contact AUSA Holton at (503) 727-1128.

The **Bennett** case is being prosecuted by Ellyn Sternfield, Attorney-in-Charge of the Medicaid Fraud Unit at the Oregon Department of Justice, who has been appointed to serve as a Special Assistant United States Attorney to handle health care matters. For further information on this case, you may contact Ms. Sternfield at (503) 229-5725.

The civil investigations and settlement negotiations in all cases were handled by AUSA Robert Nesler. For further information, you may reach AUSA Nesler at (503) 727-1069.

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[1] Mr. Bennett has pleaded not guilty to the charges against him. The charges are merely accusations, and Mr. Bennett is presumed innocent unless and until proven guilty.

HEALTH CARE FRAUD CASE SUMMARIES

Family Medical Management Services, Inc. Investigation

Defendants	Charges	Maximum Criminal Penalty	Loss	Civil Settlement
Sherrie Day Administrative Officer	2 counts of 18 U.S.C. § 1035 (health care false statements)	5 years imprisonment	$29,542	•$400,000 •exclusion from federal health plans
Family Medical Management Services	2 counts of 18 U.S.C. § 1347 (health care fraud)	5 years probation	$199,748	

Family Medical operated a chain of health care clinics in Oregon and Washington, providing services to TRICARE and Medicare beneficiaries. (TRICARE is the Defense Department's health insurance plan for families of active duty personnel.) **Family Medical** systematically claimed that its Medical Director had performed nearly all of its health care services, when in fact nurse practitioners provided the vast majority of the services. In some instances, **Family Medical** claimed that the Medical Director had provided services at times when he was in fact on vacation outside the United States. **Family Medical** was thus reimbursed by Medicare and TRICARE at a higher rate than was warranted for services provided by nurse practitioners.

Family Medical had its billing software altered to systematize the fraud. **Family Medical** filed over 6,300 fraudulent claims with TRICARE for an overpayment of approximately $161,825, and over 6,100 fraudulent claims with Medicare, for an overpayment of approximately $37,923.

West Coast Medical Supply, LLC Investigation

Defendants	Charges	Maximum Criminal Penalty	Loss	Civil Settlement
Efiong Okon, President	42 U.S.C. § 1320a-b7 (kickbacks in Medicare)	5 years imprisonment	$23,697	•$2.07 million •exclusion from federal health plans
West Coast Medical Supply LLC	18 U.S.C. § 1347 (health care fraud)	5 years probation	$1,035,328	

West Coast was a provider of durable medical equipment such as motorized wheelchairs for Medicare beneficiaries. **West Coast** repeatedly filed claims for equipment which it never actually provided. For example, **West Coast** sought reimbursement from Medicare for nearly 200 motorized wheelchairs it claimed to have provided; in fact **West Coast** provided a power-operated vehicle known as a "scooter" rather than a wheelchair in nearly every case. Scooters are much less expensive than motorized wheelchairs and do not meet the medical requirements of persons in need of motorized wheelchairs. The total loss to Medicare was over $1 million.

Bay Area Foot Clinic Investigation

Defendant	Charges	Maximum Criminal Penalty
William A. Bennett, D.P.M.	2 counts of 18 U.S.C. § 1035 (health care false statements)	5 years imprisonment $250,000 fine

A two count felony Information was filed today in this investigation. (**Bennett** waived indictment by grand jury). The Information alleges that **Bennett,** a podiatrist, falsified medical records and made a false statement in a claim for reimbursement from the Medicare and Medicaid programs. Specifically, the Information alleges that on a certain date, **Bennett** claimed reimbursement for "debridement," a surgical procedure relating to toe nails, when in fact he did not provide that service but merely clipped the nails of the patient.

The charges are merely accusations, and the defendant is presumed innocent unless and until proven guilty.

The case was investigated jointly by the Federal Bureau of Investigation, the Department of Health and Human Services Office of Inspector General, and the Oregon Department of Justice Medicaid Fraud Unit.

UNDER SEAL

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

UNITED STATES OF AMERICA	)	RECVD 05 FEB 11 14:20 USDC-ORP
	)	**CR No. 05-** 59-BR
v.	)	
	)	**FELONY**
	)	**INFORMATION**
EFIONG OKON,	)	**42 U.S.C. § 1320a-7b(b)(2)(A)**
	)	**(Health Care Program Kickback)**
	)	
	)	
	)	
Defendant.	)	

THE UNITED STATES ATTORNEY CHARGES:

On or about and between June 23, 2003 and October 9, 2003, in the District of Oregon and elsewhere, the defendant **EFIONG OKON** knowingly and willfully offered and paid cash remuneration in the total amount $23,697.92 to three persons in order to induce these persons to refer individuals to a company owned by the defendant **EFIONG OKON** for purposes of furnishing these individuals wheelchairs, which are items for which payment may be made under a Federal health care program, namely, the Medicare program, all in violation of Title 42, United States Code, Section 1320a-7b(b)(2)(A).

DATED this 11th day of February, 2005.

KARIN J. IMMERGUT
United States Attorney
District of Oregon

By: DWIGHT C. HOLTON
Assistant United States Attorney

UNDER SEAL

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

UNITED STATES OF AMERICA	)	
	)	CR 05- 58-HA
v.	)	
	)	FELONY
	)	INFORMATION
	)	18 U.S.C. § 1347 (Health Care Fraud)
WEST COAST MEDICAL SUPPLY L.L.C.,	)	
	)	
Defendant.	)	

THE UNITED STATES ATTORNEY CHARGES:

Introduction and Overview

At all times relevant to this Information

1. The defendant **West Coast Medical Supply, L.L.C.**, ("West Coast") was an Oregon corporation owned an operated by Efiong Okon.

2. Medicare is a federally funded health care plan that provides health insurance for elderly and some disabled Americans. Medicare contracts health care professionals and suppliers of medical equipment to provide services to its beneficiaries at specified rates. Medicare has established rules, policies and procedures governing the conduct of providers who contract with them; providers agree in their initial contracts with Medicare to abide by these rules, policies and procedures.

3. In 2002, **West Coast** applied to become an authorized supplier of Durable Medical Equipment to beneficiaries of the Medicare program. The term Durable Medical Equipment ("DME") refers to a broad array equipment ranging from motorized wheelchairs to specialized beds and mattresses and other equipment. The **West Coast** application was granted in June 2002.

4. The Medicare program establishes strict requirements governing when a physician may prescribe DME (that is, when a beneficiary is qualified), and when a medical supplier may appropriately bill for DME provided to a beneficiary. These requirements are essential to prevent unnecessary provision of exceedingly expensive DME to beneficiaries – in other words, to prevent profiteering by physicians or medical supply companies through provision of DME to beneficiaries who are not actually eligible to receive them.

5. Once approved as a supplier for Medicare beneficiaries, a medical supply company may seek reimbursement for DME provided to a Medicare beneficiary either by submitting a written form, or by filing electronically using billing software designated by the Medicare program.

6. A Certificate of Medical Necessity (CMN) is also required before a provider may bill Medicare for certain medical equipment. The medical equipment supply company must receive a signed CMN from the treating physician prior to submitting a claim to Medicare.

7. A DME supplier may not submit a claim unless it has actually provided the equipment to the beneficiary.

8. Certain Medicare beneficiaries are entitled to motorized wheelchairs due to their disability. Motorized wheelchairs can be extremely expensive – often costing nearly $5,000 per unit when bundled with other necessary equipment such as a specialized battery, and "anti-tipping" device, and other equipment.

9. Some beneficiaries not eligible to receive motorized wheelchairs may be eligible to obtain power-operated vehicles known as "scooters." Scooters are also extremely expensive equipment, although much less expensive than motorized wheelchairs: Medicare typically pays in the neighborhood of $2000 in reimbursement for scooters; the approximate wholesale price for a scooter ranges from $850 - $1000, depending on the model.

10. Because of the risk of fraud, and in order to account for high-priced expenditures, Medicare has very specific requirements for reimbursing providers for high-priced DME, including motorized wheelchairs. A CMN is required for motorized wheelchairs and the prescribing physician must certify that the patient, a) requires and uses a wheelchair to move around in their residence; b) has severe weakness of the upper extremities due to a neurologic, muscular, or cardiopulmonary disease/condition, and; c) is unable to operate any type of manual wheelchair.

The Fraudulent Scheme and West Coast's Methods and Means Of Executing the Scheme

11. On repeated occasions during the period June 2002 through March 2004, **West Coast** sought and received reimbursement from Medicare for wheelchairs it claimed to have provided beneficiaries when in fact it had provided those beneficiaries lower-cost scooters, reaping hundreds of thousands of dollars in excess reimbursement. In some cases, beneficiaries were provided no equipment at all.

COUNT 1: HEALTH CARE FRAUD
(18 U.S.C. § 1347)

12. Scheme and Artifice to Defraud. As outlined in detail in Paragraphs 1 - 11, which are realleged and incorporated as though set forth fully herein, **West Coast Medical Supply, L.L.C.** undertook a scheme by which it falsely represented to Medicare that it had provided Medicare beneficiaries with durable medical equipment when in fact, as **West Coast Medical Supply L.L.C.** knew, it had not provided the durable medical equipment as represented to Medicare.

13. On or about and between June 2002 and March 2004, both dates being approximate and inclusive, the defendant **West Coast Medical Supply L.L.C.** knowingly and willfully executed a scheme and artifice to defraud a health care benefit program, namely

Medicare, in connection with the payment for health care items.

DATED this 17th day of February, 2005.

KARIN J. IMMERGUT
United States Attorney
District of Oregon

By: DWIGHT C. HOLTON
Assistant United States Attorney

UNDER SEAL

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

UNITED STATES OF AMERICA	)	RECVD 05 FEB 11 14:30 USDC-ORP
	)	**CR No. 05-** 01-RE
v.	)	
	)	**INFORMATION**
SHERRIE DAY,	)	**18 U.S.C. §§ 2 and 1035 (False Statement)**
	)	
	)	
	)	
	)	
Defendant.	)	

THE UNITED STATES ATTORNEY CHARGES:

COUNT 1:

On or about May 2, 2002, in the District of Oregon, the defendant **SHERRIE DAY,** knowingly and willfully made a materially false statement in connection with the payment for health care services involving a health care benefit program, in that she filed a claim for reimbursement from the Tricare health plan for health care services provided to a Tricare beneficiary described here as Jane Doe, and falsely stated on that claim for reimbursement that the services had been provided to Jane Doe by a physician, when in fact, as the defendant **SHERRIE DAY** then and there well knew, the services had been provided by a nurse practitioner, for whom services are reimbursed at a lower rate, all in violation of Title 18, United States Code, Sections 2 and 1035.

COUNT 2:

On or about November 7, 2002, in the District of Oregon, the defendant **SHERRIE DAY,** knowingly and willfully made a materially false statement in connection with the

payment for health care services involving a health care benefit program, in that she filed a claim for reimbursement from the Medicare health plan for services provided to a Medicare beneficiary described here as John Doe, and falsely stated on that claim for reimbursement that the services had been provided to John Doe by a physician, when in fact, as the defendant **SHERRIE DAY** then and there well knew, the services had been provided by a nurse practitioner, for whom services are reimbursed at a lower rate, all in violation of Title 18, United States Code, Sections 2 and 1035.

DATED this 12th day of February, 2005.

KARIN J. IMMERGUT
United States Attorney
District of Oregon

By: DWIGHT C. HOLTON
Assistant United States Attorney

UNDER SEAL

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

UNITED STATES OF AMERICA	)	
	)	**CR 05-** 60-BR
v.	)	
	)	**INFORMATION**
	)	**18 U.S.C. § 1347 (Health Care Fraud)**
FAMILY MEDICAL MANAGEMENT SERVICES, INC.,	)	
	)	
Defendant.	)	

THE UNITED STATES ATTORNEY CHARGES:

Introduction and Overview

At all times relevant to this Information

1. The defendant **Family Medical Management Services, Inc.** ("Family Medical") was an Oregon corporation which operated health care clinics in Oregon and Washington. **Family Medical** was incorporated in the State of Oregon on January 15, 1997. At various times, and through related companies, **Family Medical** operated clinics in Portland, Salem, and Aloha, Oregon, as well as in Vancouver, Washington, including:

(A) the Lloyd Center Family Medical Clinic, Lloyd Center Mall, Ste 2252, Portland, Oregon;

(B) the Farmington Mall Medical Clinic, 17455 SW Farmington Road, Aloha, Oregon;

(C) the Cascade Medical Center, 1233 Edgewater NW, Salem, Oregon;

(D) the Lancaster Urgent Care Clinic, 1880 Lancaster Drive NE, Salem, Oregon;

and

(E) the Cascade Park Family Medical Clinic, 411 NE 87th Ave, Vancouver, Washington.

2. Beginning in approximately 1997, clinics operated by **Family Medical** provided health care services to beneficiaries of two federal health care programs: the TRICARE program and the Medicare program.

3. TRICARE is a comprehensive health care plan that is federally funded, regionally managed, and is designed to provide health care insurance coverage for active duty and retired members of the uniformed services, their families, and survivors who are not eligible for Medicare. TRICARE contracts with health care professionals to provide services to its beneficiaries at specified rates.

4. Medicare is a federally funded health care plan that provides health insurance for elderly and some disabled Americans. Medicare likewise contracts health care professionals to provide services to its beneficiaries at specified rates. Both TRICARE and Medicare have established rules, policies and procedures governing the conduct of providers who contract with them; providers agree in their initial contracts with TRICARE and Medicare to abide by these rules, policies and procedures.

5. **Family Medical** provided the vast majority of its health care services by hiring nurse practitioners and physician's assistants to see and treat patients at its clinics. Nurse practitioners and physician's assistants are skilled medical professionals qualified under Oregon law to see and treat patients independent of physician supervision. **Family Medical** employed approximately eleven nurse practitioners and physician's assistants during the period 1998 through 2003.

6. **Family Medical** did have one physician on staff during the entire period 1998 through 2003, and one other physician who worked for **Family Medical** for several months, but the vast majority of services was provided by the nurse practitioners and physician's assistants on staff.

7. To obtain reimbursement for providing services to TRICARE and Medicare beneficiaries, **Family Medical** regularly filed claims for reimbursement from TRICARE and Medicare. As a general matter, claims for reimbursement from TRICARE and Medicare can be filed electronically or by paper claim.

8. TRICARE and Medicare reimbursement claim forms, whether electronic or paper, require the claimant to attest to the truth and accuracy of the information provided in the claim form.

9. During the period 1998 through 2003; **Family Medical** filed more than 40,000 claims for reimbursement from TRICARE, and more than 18,000 claims for reimbursement from Medicare.

10. To obtain reimbursement from TRICARE and Medicare, a health care provider – whether a physician, nurse practitioner or physician's assistant – must generally obtain a "provider identification number" from TRICARE and Medicare.

11. Providers claiming reimbursement from TRICARE and Medicare are required to identify the actual provider of the health care services on every claim for reimbursement.

The Fraudulent Scheme and Family Medical's Methods and Means Of Executing the Scheme

12. Both TRICARE and Medicare pay a higher reimbursement for certain health services when provided by a physician than for those same services when provided by a nurse

practitioner or physician's assistant. The higher reimbursement rates reflect the higher skill level and more thorough training requirements imposed on physicians.

13. To determine which reimbursement rate applies, TRICARE and Medicare require a provider seeking reimbursement to specify the name and identification number of the provider who performed the services on the claim for reimbursement – thus, TRICARE and Medicare can reimburse physicians at the physician rate, and nurse practitioners and physician's assistants at the lower rate.

14. During the period 1998 through March 2003, **Family Medical** fraudulently claimed that its sole physician had performed nearly all of the health care services provided by **Family Medical**, when in fact he performed only a fraction of the services, and the vast majority of the services was provided by nurse practitioners and physician's assistants. **Family Medical** was thus reimbursed at the higher physician rate for services in fact provided by nurse practitioners and physician's assistants.

15. To ensure that it was systematically reimbursed at the higher physician rate, **Family Medical** had its billing software altered so that in generating claims for reimbursement from TRICARE and Medicare, the software automatically replaced the name of the provider who actually provided the service with the name and provider identification number of the clinic's sole physician.

16. Although the billing software was altered to show the sole physician as the service provider, staff at **Family Medical** periodically created and reviewed productivity reports which identified the true providers of health care services – and thus knew which providers had actually provided the services reported as having been provided by the sole physician on staff.

17. Because **Family Medical** systematically claimed its sole physician as the provider

of its health services, regardless of who the actual provider was, **Family Medical** regularly claimed reimbursement for services provided by this provider when he was in fact out of the country on vacation. **Family Medical** also regularly claimed its sole physician as the provider of services which were in fact rendered in two different cities on the same day and time.

18. **Family Medical** failed to obtain provider identification numbers for most of the nurse practitioners working for its clinics: since **Family Medical** almost exclusively used its sole physician's identification number in claiming reimbursement, **Family Medical** did not have any use for numbers for other providers.

19. During the period 1998 through March 2003, **Family Medical** filed in excess of 6,300 claims for reimbursement from TRICARE in which **Family Medical** fraudulently claimed that the services claimed had been provided by its sole physician, when in fact the services had been provided by a nurse practitioner or physician's assistant. The fraudulent claims resulted in an overpayment to **Family Medical** of approximately $161,825 by TRICARE during the period 1998 through March 2003.

20. During the period 1998 through March 2003, **Family Medical** filed in excess of 6,100 claims for reimbursement from Medicare in which **Family Medical** fraudulently claimed that the services had been provided by its sole physician, when in fact the services had been provided by a nurse practitioner or physician's assistant. The fraudulent claims resulted in an overpayment of approximately $37,923 by Medicare during the period 1998 through March 2003.

COUNT 1: HEALTH CARE FRAUD TARGETING TRICARE
(18 U.S.C. § 1347)

21. Scheme and Artifice to Defraud. As outlined in detail in Paragraphs 1 - 20, which are realleged and incorporated as though set forth fully herein, **Family Medical Management Services, Inc.** undertook a scheme by which **Family Medical Management Services, Inc.** falsely represented to TRICARE that health care services provided to TRICARE beneficiaries were provided by a physician when in fact, as **Family Medical Management Services, Inc.** knew, the health care services were provided by a nurse practitioner or physician's assistant.

22. On or about and between 1998 and March 2003, both dates being approximate and inclusive, the defendant **Family Medical Management Services, Inc.** knowingly and willfully executed a scheme and artifice to defraud a health care benefit program, namely TRICARE, in connection with the payment for health care services.

COUNT 2: HEALTH CARE FRAUD TARGETING MEDICARE
(18 U.S.C. § 1347)

23. Scheme and Artifice to Defraud. As outlined in detail in Paragraphs 1 - 20, which are realleged and incorporated as though set forth fully herein, **Family Medical Management Services, Inc.** undertook a scheme by which **Family Medical Management Services, Inc.** falsely represented to Medicare that health care services provided to Medicare beneficiaries were provided by a physician when in fact, as **Family Medical Management Services, Inc.** knew, the health care services were provided by a nurse practitioner or physician's assistant.

24. On or about and between 1998 and March 2003, both dates being approximate and inclusive, the defendant **Family Medical Management Services, Inc.** knowingly and willfully executed a scheme and artifice to defraud a health care benefit program, namely, Medicare, in connection with the payment for health care services.

DATED this 11th day of February, 2005.

KARIN J. IMMERGUT
United States Attorney
District of Oregon

By: DWIGHT C. HOLTON
Assistant United States Attorney

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

UNITED STATES OF AMERICA,	**CR No. 05-71-BR**
v.	**FELONY INFORMATION**
WILLIAM A. BENNETT,	**18 U.S.C. §§2 and 1035(a)(2) (False Statement)**
Defendant.	**(UNDER SEAL)**

THE UNITED STATES ATTORNEY CHARGES:

At all times material to this Information:

1. The Medicaid and Medicare Programs were health care benefit programs pursuant to Title 18, United States Code Section 24(b).

2. The defendant **WILLIAM A. BENNETT** ("Bennett"), was a podiatric physician, licensed to practice in the State of Oregon. During the period from January 1999 - June 2003, Bennett practiced at the Bay Area Foot Clinic, 1980 Waite Street, Suite 1, North Bend, Oregon.

3. Bennett was an enrolled Medicare provider and an enrolled Oregon State Medicaid provider of podiatry services to Oregon Medicare and Medicaid patients. Both

programs provide payment or reimbursement for medically necessary podiatry services under certain stated rules.

4. Debridement of nails is a recognized surgical procedure to remove excess material (reduce nail thickness or excessive curvature) from a diseased or medically dystrophic nail. A dystrophic nail is one that is excessively thick due to some underlying medical condition such as mycosis (fungus caused by a chronic communicable infection). Debridement is generally performed with an instrument or electronic grinder.

5. Medicare will only pay for debridement of toenails under limited conditions, such as if the patient exhibits clinical evidence of mycosis or another qualifying medical condition, plus expressed pain. Medicare does not cover routine toenail clipping. Medicaid will pay a podiatrist for providing toenail trimming, but at a lesser payment rate than debridement.

COUNT 1

6. Paragraphs One through Five are realleged and incorporated as if set forth fully herein.

7. On or about April 24, 2003, in the District of Oregon, defendant **WILLIAM A. BENNETT**, knowingly and willfully made a materially false statement in connection with the delivery of and payment for health care services involving health care benefit programs in that defendant **WILLIAM A. BENNETT** falsified medical records used to support billings to Medicaid and Medicare, to indicate that a patient "JA" complained of pain; that patient JA had underlying medical conditions; and that defendant provided debridement services to JA, when in fact as defendant **WILLIAM A. BENNETT** then and there well knew, JA did not complain of

pain, JA did not have the recorded medical conditions, and the defendant did not provide JA with debridement services, all in violation of Title 18, United States Code, Sections 2 and 1035.

COUNT 2

8. Paragraphs One through Five are realleged and incorporated as if set forth fully herein.

9. On or about May 21, 2003, in the District of Oregon, the defendant **WILLIAM A. BENNETT**, knowingly and willfully made a materially false statement in connection with the payment for health care services from health care benefit programs, in that defendant **WILLIAM A. BENNETT** filed a claim for reimbursement from Medicare and Medicaid for services provided to a patient "JA", and falsely stated on the claim for reimbursement that patient JA was experiencing foot pain; that JA had certain medical conditions; and that defendant provided debridement services to JA, when in fact as defendant **WILLIAM A. BENNETT** then and there well knew, JA did not have foot pain, did not have the medical conditions defendant reported on the claim, and the defendant did not provide JA the billed debridement services, all in violation of Title 18 United States Code, Sections 2 and 1035.

Dated this 17th day of February, 2005.

KARIN J. IMMERGUT
United States Attorney
District of Oregon

By: ELLYN L. STERNFIELD, OSB # 92182
Special Assistant United States Attorney

ALLAN M. GARTEN, OSB # 81236
Assistant U.S. Attorney