DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

State Medicaid Fraud Control Units

Annual Report
Fiscal Years 2004 and 2005

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Summary

This is the 15th Office of Inspector General (OIG) Annual Report on the State Medicaid Fraud Control Units (MFCU). This report covers the Federal fiscal years (FY) 2004 and 2005, commencing October 1, 2003, and ending September 30, 2005.

During the two reporting periods, 48 States and the District of Columbia participated in the Medicaid fraud control grant program through their established MFCUs. The mission of the MFCUs is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect. MFCUs' authority to investigate and prosecute cases involving Medicaid provider fraud and patient abuse and neglect varies from State to State. Forty-two of the MFCUs are located within Offices of State Attorneys General. The remaining seven MFCUs are located in various other State agencies.

In FY 2004, MFCUs recovered more than $572 million in court-ordered restitution, fines, civil settlements, and penalties. MFCUs reported total recoveries of more than $709 million in FY 2005. They also obtained 1,160 convictions in FY 2004 and 1,123 convictions in FY 2005. For the two fiscal years, MFCUs reported a total of 1,409 instances in which a civil action was undertaken that resulted in a successful outcome. Of the 7,099 providers that OIG excluded from participation in the Medicare and Medicaid programs and other Federal health care programs for the two fiscal years, 1,267 exclusions were based on referrals made to OIG by the MFCUs.

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State Medicaid Fraud Control Units
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Medicaid Program

The Medicaid program was established in 1965 by Title XIX of the Social Security Act (the Act) to provide health care services to low-income and disabled Americans. It is the largest Government health care program, surpassing Medicare for the first time in 2002. Federal and State governments share in the cost of providing services to eligible Medicaid beneficiaries. Medicaid program expenditures totaled $296 billion in FY 2004 and $315 billion in FY 2005. The Federal share of Medicaid expenditures is calculated using the Federal medical assistance percentage (FMAP) rate established for each State as well as Federal matching of 50-percent or more for various categories of administrative costs. Federal grant awards made to the MFCUs are generally funded on a 75-percent matching basis, with the States contributing the remaining 25-percent funding.

Within broad national guidelines set by the Federal Government, the Act enables States to furnish medical assistance to those who meet eligibility requirements. Within Federal guidelines, each State administers its own Medicaid program; sets its own eligibility standards; determines the type, amount, duration, and scope of services; and sets payment rates**.** States have the option of providing Medicaid services either on a fee-for-service basis, in which an enrolled provider is reimbursed on a claim-by-claim basis for each covered service it provides, or through a variety of managed care arrangements as part of a State plan waiver program.

Oversight of the Medicaid Fraud Control Units

The Office of Inspector General (OIG) was established in 1976. The mission of OIG is to protect the integrity of Department of Health and Human Services (HHS) programs and the health and welfare of beneficiaries of HHS programs. OIG has a responsibility to report, both to the Secretary of HHS and to Congress, program and management problems and to make recommendations to correct them. OIG's duties are carried out through a nationwide network of audits, investigations, evaluations, and other mission-related functions. OIG's Medicaid Fraud Unit Oversight Division (MFUOD), contained within the Office of Evaluation and Inspections, is responsible for overseeing the activities of the 49 MFCUs.

The Omnibus Budget Reconciliation Act of 1993, section 13625, as codified in section 1902(a)(61) of the Act, required OIG to develop performance standards for assessing MFCUs. This section also required all States to operate a MFCU or receive a waiver from the Federal Government.

The performance standards were created in consultation with the MFCU community and were made effective on September 26, 1994. OIG uses the performance standards as guidelines to assess the effectiveness and efficiency of MFCUs and to determine whether they are carrying out their duties and responsibilities in an effective manner.

Certification/Recertification

Each State establishing a MFCU must submit an initial application for certification to the Secretary of HHS. When establishing a MFCU, a State must also meet several major requirements to obtain both Federal certification and grant funding for the proposed MFCU. These requirements state that a MFCU must be a single, identifiable entity of the State Government and include: (1) one or more attorneys experienced in the investigation or prosecution of civil fraud or criminal cases, who are capable of giving informed advice on applicable law and procedures and providing effective prosecution or liaison with other prosecutors; (2) one or more experienced auditors capable of supervising the review of financial records and advising or assisting in the investigation of alleged fraud; and (3) a senior investigator with substantial experience in commercial or financial investigations who is capable of supervising and directing the investigative activities of the unit. The Secretary of HHS notifies the submitting State whether its application meets the Federal requirements for initial certification and whether the application is approved. The initial application approval and certification by the Secretary are valid for a 1-year period.

For an established MFCU to continue receiving Federal certification and grant funding from HHS, it must submit a reapplication each year to OIG at least 60 days prior to the end of its current certification period. In considering a MFCU's eligibility for recertification, OIG thoroughly reviews the reapplication. OIG assesses whether the MFCU seeking recertification fully complied with the 12 performance standards and whether Federal resources expended by the MFCU were effectively used in detecting, investigating, and prosecuting Medicaid fraud and patient abuse and neglect cases. If applicable, OIG staff will also evaluate the results of any onsite reviews that were conducted during the MFCU's certification period. Once all submitted information is reviewed and assessed, the MFCU is notified in writing that its reapplication for recertification is approved or denied.

Surveillance and Utilization Review Sub-system

The State Medicaid agencies, with a few exceptions, are required to maintain a Medicaid Management Information System (MMIS). The MMIS is a claims payment and information retrieval system. A vital part of the MMIS is the Surveillance and Utilization Review Sub-system (SUR/S). SUR/S has two primary purposes: (1) to process information on medical and health care services that guide Medicaid program managers, and (2) to identify the providers (and recipients) most likely to commit fraud against the Medicaid program. In addition, MFCUs and their respective State Medicaid agencies are required to enter into a Memorandum of Understanding (MOU). The MOU is intended to: (1) facilitate the referral of all suspected cases of provider fraud to the State MFCU, and (2) facilitate the exchange of information between the Medicaid agency and the MFCU.

When providers with aberrant patterns or practices are identified by SUR/S, that information should be made available to the MFCU. Most MFCUs rely on referrals from the SUR/S or the Medicaid agency to initiate many of their case investigations. Cooperation between a State's MFCU and Medicaid agency fosters a more efficient process of identifying and prosecuting fraud in the Medicaid program.

Grant Expenditures

In FY 2004, HHS awarded MFCUs more than $131 million in Federal grant funds. Grant awards made available to the MFCUs in FY 2005 exceeded $144 million. The number of individuals employed by MFCUs in FY 2004 was 1,609. That number increased in FY 2005 to 1,725 employees. Since the inception of the Medicaid fraud control grant program, Federal funds awarded to MFCUs have increased from $9.1 million in FY 1978 to more than $144.3 million in FY 2005.

Accomplishments

Collectively, in FY 2004, the 49 MFCUs claimed total recoveries of more than $572 million in court-ordered restitution, fines, civil settlements, and penalties. The number of convictions obtained for the period was 1,160. The number of civil actions that resulted in successful outcomes in FY 2004 was 776. Of the 3,293 individuals and entities excluded from participation in the Medicare and Medicaid programs in FY 2004 by OIG, 530 were based on referrals made to OIG by MFCUs.

In FY 2005, the MFCUs reported to OIG total recoveries of more than $709 million. During that period, 1,123 convictions were obtained. MFCUs reported 633 civil actions that had a successful outcome. In FY 2005, OIG excluded 3,806 individuals and entities from participation in the Medicare and Medicaid programs, and of that number 737 were based on referrals received from MFCUs.

It is important to point out that statistical information alone does not reflect the full measure of the MFCUs' accomplishments or successes. MFCU cases involving abuse and neglect of beneficiaries in Medicaid-funded facilities as well as board and care facilities usually do not generate substantial monetary returns to a State's Medicaid program. Nevertheless, the investigation and prosecution of these cases by MFCUs is widely viewed as critical to providing high-quality health care services to particularly vulnerable beneficiaries.

In addition, MFCUs routinely engage in other noteworthy endeavors that are difficult to quantify. Such endeavors include, but are not limited to: (1) legislative proposals affecting the Medicaid program presented to State legislatures; (2) recommendations made to respective State Medicaid agencies to effect positive change to Medicaid policies and regulations; and (3) participation in joint case investigations/prosecutions with other State agencies, the Federal Government, and other State MFCUs.

Case Narratives FY 2004

The following are examples of Medicaid fraud and patient abuse and neglect case investigations and prosecutions conducted by MFCUs in FY 2004.

Clinic

In Ohio, the owner of a medical clinic (and the clinic's parent corporation) were found guilty of committing fraud against Medicaid, Medicare, the Bureau of Workers Compensation (BWC), and private insurance companies. A joint undercover investigation conducted by the Ohio MFCU, HHS OIG, and BWC found that the owner billed for services not rendered to patients, provided unnecessary or unauthorized medical services, and intentionally billed incorrect CPT codes for higher reimbursements. Interviews with the clinic's staff revealed that the owner was responsible for a range of fraudulent activities from miscoding, to falsifying medical charts, to overriding doctors' orders to support billing for higher claims. Restitution was ordered in the amount of $3.5 million. The defendant/owner was sentenced to 6 months of house arrest and was ordered to sell the business. Both the clinic's parent corporation and defendant/owner were ordered to pay $100,000 for investigation and prosecution costs and to pay court fees.

Dentists

The Montana MFCU investigated a dentist based on allegations that he had billed for services not completed and that his practices were professionally questionable. A system inquiry showed a high utilization of some codes by the dentist. Further investigation revealed that he billed services at a higher code, failed to complete services in many instances, and maximized every service code available. At the conclusion of the MFCU's investigation, the U.S. Attorney's Office notified the dentist of its intent to file a Federal False Claims Act lawsuit against him for triple damages with an identified fraud amount of $131,000. In response, the dentist agreed to a pre-filing settlement for $220,000. He was also excluded from participation in the Medicaid program.

In the District of Columbia, a dentist pled guilty to one count of health care fraud. The defendant was a participating provider in a number of dental care programs and was paid fixed fees for providing routine services to patients; the defendant was also entitled to supplemental reimbursement for providing more invasive procedures. In entering a guilty plea, the defendant admitted overbilling for invasive procedures for at least 60 Medicaid recipients when in fact no such procedures were performed. As part of the plea agreement, the defendant paid $15,374 to the Medicaid program, was sentenced to 2 years' probation, and was ordered to undergo evaluation and treatment for drug abuse. The defendant was also excluded from participation in all Federal health care programs.

Durable Medical Equipment

In Florida, a durable medical equipment (DME) company agreed to pay more than $1.3 million to settle allegations that it fraudulently billed the Medicare and Medicaid programs by double billing and submitting false claims for medical equipment sales. An investigation conducted by the Florida MFCU and the U.S. Attorney's Office revealed that the DME company improperly billed both programs for certain DME items, such as wheelchairs and nebulizer supplies. When the company was sold in 1999, the new owners discovered the improper billings and made disclosure to the proper authorities in the State. In the settlement, the State received more than $777,000, and of this amount approximately $383,000 was returned to the Medicaid program. The remainder of the settlement, approximately $329,000, constituted the additional penalties assessed. The U.S. Attorney's Office also recovered $608,000 for the Medicare program.

In Colorado, a DME provider was convicted of theft of more than $15 million, a class three felony, and was sentenced to 3 years' probation with 117 days of time served in prison. The investigation by the Colorado MFCU showed that the defendant set up a corporation and bank account as a DME provider. He obtained the names and Medicaid numbers of elderly beneficiaries in the Denver area and fraudulently billed Medicaid for thousands of dollars of DME. In interviews with MFCU investigators, Medicaid beneficiaries confirmed that they neither required nor received the DME billed on their behalf by the defendant's company. Although the defendant's scheme was quickly discovered, he had already received more than $45,000 in electronic funds transfers from Medicaid. Conditions of the defendant's probation included monitoring, paying extradition costs from California (where he had fled), paying restitution in the amount of approximately $47,000 and maintaining full-time employment.

Health Care Services

In Maryland, the owner and operator of a health care franchise specializing in providing nursing and other health care services to Medicaid recipients pled guilty to one count of felony theft for fraud. Before the defendant pled guilty, the (parent) franchiser company settled with the State by agreeing to pay approximately $1.3 million in overpayments, penalties, and costs related to the defendant's fraudulent submissions from which the (parent) company had benefited. The Maryland MFCU negotiated the settlement. The defendant failed to disclose to the Medicaid program that he owned a medical supply company from which his health care franchise business purchased its supplies. The investigation revealed that the defendant illegally marked up his supply costs by 40 percent when sending cost reports to the (parent) franchiser company. He also included additional fraudulent costs on his cost reports. The defendant was sentenced to 8 years in prison, with 27 months to be served and the rest suspended, and 5 years' probation. He was also ordered to pay $1 million in restitution and penalties.

Home Health Care

In Washington, an in-home personal care aide pled guilty to two counts of making a false statement to Medicaid. The defendant was sentenced to serve 30 days in prison on each count (converted to 240 hours of community service) and 12 months' probation. The defendant was also ordered to pay $24,730 in restitution to the State's Medicaid program. The defendant contracted with Medicaid to provide in-home personal care services to patients under a Medicaid Individual Personal Care program. Under this program, to receive payment, the defendant was permitted to telephone in the hours worked in a preceding month. Over a 13-month period, it was found that the defendant had telephoned in several hours to Medicaid for payment for work that was never performed. Medicaid, in keeping with the contract, paid the defendant for the hours that were reported.

A home health care aide in Nevada was sentenced to perform 60 hours of community service and ordered to pay $35,000 in penalties, restitution, and investigative costs for falsifying records concerning the types of health care services that were being provided to Medicaid recipients. The false information was given to the defendant's employer who in turn used the information as a basis to submit bills to Medicaid for payment.

Laboratory

In Illinois, as a result of an audit conducted by the Illinois Department of Public Aid (IDPA), a medical laboratory owner was indicted on 17 separate counts, including violations of health care fraud statutes, mail fraud, and filing false claims. The IDPA audit determined that the laboratory records showed numerous discrepancies, including tests performed without a doctor's authorization and no records to support billings made to the Medicaid program. As a result of IDPA's audit, a Medicaid Fraud Control Bureau (MFCB) investigation was begun. MFCB's investigation identified numerous tests as having been falsely billed to both Medicare and Medicaid by the lab's owner. MFCB investigators also found that the lab owner had falsely billed both programs for services not rendered and submitted false mileage claims to the Medicare program. The defendant pled guilty to two counts of Federal mail fraud. He also admitted not having performed the tests outlined in the multicount indictment. He was sentenced to serve 60 months' imprisonment and was ordered to pay more than $3.2 million in restitution to the Medicare and Medicaid programs.

Mental Health Services

The Virginia MFCU conducted a joint investigation with the F.B.I. and U.S. Department of Justice which resulted in the convictions and sentencing of two owners/operators of an intensive in-home mental health services company. The defendants (husband and wife) fraudulently billed the Medicaid program approximately $2.5 million for services that were not provided or covered. The husband was sentenced to 46 months in prison. His wife was sentenced to 6 months' imprisonment and 6 months of electronic monitoring. The defendants were jointly ordered to repay $2.5 million to the Virginia Medicaid program.

In Texas, co-owners of a licensed professional counseling (LPC) business were indicted on theft charges for stealing an estimated $646,000 from the Medicaid program over a 1-year period. The co-owners (husband and wife) billed Medicaid for LPC services that were not rendered. The wife received a record prison sentence of 63 years and the husband was sentenced to 35 years' incarceration. The defendants hold the records for the longest and second-longest fraud sentences in Texas MFCU history.

In Pennsylvania, a behavioral therapist pled guilty to four counts of Medicaid fraud and four counts of insurance fraud. The offenses involved false claims submitted by the defendant to Medicaid managed health care contractors for behavioral health services. Investigation revealed that the defendant submitted reports and billing encounter forms to her employer with dates and times for units of services that were not actually provided. It was also found that the defendant fabricated mental health records and falsified parent-guardian signatures on billing encounter forms. The defendant was sentenced to 7 years' probation and ordered to pay $36,681 in restitution to the Medicaid program.

Nurses/Nurses Aides

In Rhode Island, a licensed practical nurse (LPN) working in a hospital setting pled no contest to three counts of larceny of a controlled substance. The LPN received a 3-year sentence, suspended with probation. He was also ordered to undergo drug screening and treatment, as well as surrender his nursing license for the period of probation. An internal audit of the hospital's inventoried medications showed that the LPN had made excessive narcotic withdrawals of Oxycodone and Hyrocodone.

In North Carolina, two nurse aides at a health care center each pled guilty to one count of simple assault. The two defendants dragged a resident by her feet through the halls of the facility after the resident refused to take a bath. The resident suffered floor and carpet burns to her back as a result of the assault. One of the defendants was sentenced to 30 days in custody, suspended, and was placed on 12 months' probation. The second defendant received a continued judgment on the condition that $1,000 in court costs be paid and her assurance that she would not commit any other crimes.

In Mississippi, an LPN working in a nursing home was found guilty on three counts of falsification of medical records, a misdemeanor. The LPN falsified patient medical charts by indicating that residents were given medication when they actually were not. The nurse was ordered to pay a $250 fine and $216 in court costs.

Nursing Home

In Vermont, the director of social services at a nursing home pled guilty to one count of false pretenses, two counts of abuse of a vulnerable adult, and a violation of probation. The defendant stole confidential information from the resident's nursing home records. In one instance, the defendant used information from a resident's file to make unauthorized cash withdrawals from that resident's credit card account, and then transferred the funds to her own personal bank account. In a second incident, the defendant applied for a credit card in the name of a resident, and then used the card to make purchases of more than $2,000. In a third instance, the defendant applied for a personal loan using both her own name and a resident's name. At the time the defendant committed the offenses at the nursing home, she was on probation for grand larceny. For the crimes committed, the defendant was sentenced to serve 1 year in jail with an underlying sentence of 7 to 10 years in jail, and ordered to pay $3,134 in restitution to the victims.

Orthopedic

In Massachusetts, 16 members of the Massachusetts orthopedic footwear industry agreed to pay $548,000 to the Medicaid program to settle allegations of receiving numerous overpayments as a result of incorrect billing practices and documentation deficiencies. The settlement followed a report produced by the State's Inspector General that concluded that, between July 1995 and January 1999, approximately 65 percent of all Medicaid orthopedic shoe transactions had resulted in overpayments. The overpayments occurred as a result of providers' billing excessive amounts, billing twice for services provided only once, improperly increasing reimbursements by utilizing erroneous service codes, and improperly billing for separate components of off-the-shelf and custom orthopedic shoes and inserts. Subsequently, the Massachusetts MFCU opened an investigation of the orthopedic footwear industry's billing, coding, and record keeping practices. That investigation found that the majority of orthopedic footwear providers had submitted incorrect claims for orthopedic shoes and inserts which resulted in their receiving payments in excess of the maximum amount allowable for such products. The orthopedic shoe providers agreed to a settlement in the amount of $548,000. Because they were permitted to continue to participate in the Medicaid program, the orthopedic shoe providers agreed to institute comprehensive compliance programs to ensure full compliance with all applicable Medicaid regulations in the future.

Patient Abuse and Neglect

In Wisconsin, an administrator of a senior living board and care residential facility pled guilty to one count of felony neglect and two counts of making fraudulent insurance claims. The defendant not only concealed the fact that a resident of the facility was suffering from a severe ulcer, but also threatened any other staff members who attempted to report the resident's condition to the facility's medical staff. The causation of the resident's eventual death from an infection was traced to the negligence and nonaction of the defendant**.** The defendant received a stayed sentence of 10 years' imprisonment, 10 years' extended supervision, and 12 years' probation with the condition that a 1-year jail term be served.

In the District of Columbia, a supervisor at a small residential facility for mentally disabled nonindependent men was sentenced to 2 years in prison for sexually assaulting one of the residents of the facility. The defendant admitted to assaulting the resident and was subsequently charged with first-degree sexual abuse of a ward. The defendant was sentenced to 3 years of supervised release and ordered to register as a sex offender for a period of 10 years. In addition, the defendant was barred from working as a caregiver for children or vulnerable adults. The defendant was also excluded from participating in Federal health care programs.

Patient Funds

In Alabama, the former Admissions Director of a nursing home pled guilty to a charge of first-degree theft of property and was sentenced to serve 5 years in prison, suspended, with 5 years of supervised probation. Beginning in April 2000, the defendant stole money from a patient's trust fund by keeping the proceeds from cashed checks. The defendant also admitted keeping cash that visiting family members brought which should have been used to pay the incidental bills of their resident family members. In addition to the imposed sentence, the defendant was also ordered to make full restitution of $33,160 and pay a $1,000 fine.

In Colorado, the business manager at a nursing home pled guilty to two counts of theft. As the business manager, the defendant had control of both the home's operating account and the residents' personal needs account. The defendant fraudulently made approximately 680 checks payable to petty cash from the home's operating account, amounting to more than $553,000. This deception caused the cost reports of the nursing home to be inflated, which resulted in the nursing home receiving additional funds from Medicaid to which it was not entitled. Following the appointment of a new administrator at the home, the defendant switched from stealing from the home's operating account to stealing from the residents' personal needs account. The defendant made approximately 86 checks payable to cash from the residents' account, which inevitably deprived the residents of the use of more than $97,000. The defendant was sentenced to 10 years in prison and was ordered to make restitution in the amount of $672,240.

In Ohio, the sole bookkeeper at a group home for the mentally challenged withdrew funds from the facility's account without consent by writing checks out to cash and then keeping the funds for her own use. The defendant also altered or forged deposit slips to keep cash that otherwise should have been deposited into the home's account. Ultimately, the defendant pled guilty to four counts of forgery, one count of theft, and one count of tampering with records. Over a 3-year period, the defendant stole a total of $31,000 from the facility. She was sentenced to one year for each forgery count, 4 years for the theft, and 6 months for records tampering. These sentences were to run concurrently. In addition, the defendant was ordered to pay $31,521.55 in restitution to the group home.

Pharmacies/Pharmacists

In Alaska, a registered pharmacist/pharmacy owner pled guilty to Medicaid fraud. The investigation began when the defendant did not comply with requests made by the Alaska MFCU to provide pharmacy records. During the investigation, a random review of the pharmacy's records revealed that, in one instance, the defendant had double and triple-billed Medicaid for prescription medications for one recipient. The defendant was sentenced to 90 days in jail (suspended), 3 years of probation, and a $1,000 fine (suspended), and was ordered to repay the Medicaid program. The defendant voluntarily surrendered his Drug Enforcement Administration certificate.

In Washington, a pharmacist was convicted of nine counts of theft in the first degree and sentenced to 38 months in prison and ordered to pay restitution of $308,000, a victim assessment fee of $710, and court costs. Following a referral made to the Washington MFCU by the Medical Audit Unit of the Department of Social and Health Services, the MFCU investigation found that from January to September 2004 the defendant had billed and collected payments from Medicaid for prescriptions that were not provided to recipients. These prescriptions were for high-cost medications most commonly used to treat chemotherapy patients. An analysis of the defendant's pharmacy inventory, which covered a 21-month period, showed no stock of these specialized medications.

In Kentucky, a pharmacist was indicted and convicted on multiple Medicaid fraud counts for billing Medicaid for high-cost cancer drugs long after the recipients had stopped using them. The defendant obtained the recipients' identifying information from legitimate prescriptions that the recipients' physicians wrote for the drugs. The defendant continued to bill Medicaid for these drugs even after patients had died or stopped using the drugs. In a very short time, the defendant defrauded the Medicaid program of more than $40,000. The defendant was sentenced to serve 5 years in prison and ordered to pay restitution of $40,000.

In New York, a pharmacy owner pled guilty to committing grand larceny in the third degree for stealing more than $800,000 from the Medicaid program. The defendant had fraudulently billed for thousands of doses of expensive AIDS medications and other drugs that were never dispensed to patients. The defendant allowed Medicaid recipients to trade their prescriptions for various over-the-counter items, and then billed Medicaid for the undispensed medication listed in the prescriptions. The defendant was sentenced to serve 6 months in jail, 5 years' probation, and ordered to repay $811,000 to the Medicaid program.

Physicians

In Texas, a Houston physician and seven codefendants were convicted of conspiring to defraud both the Medicare and Medicaid programs. The conspiracy involved providing services to ineligible beneficiaries, not providing physician supervision when physical therapy services were being performed, and receiving payments for services not rendered. During a 5-year period, seven physical therapy clinics operated by the defendants were responsible for more than $11 million in false claims submitted to Medicare and Medicaid.

Of this amount, more than $5 million was paid to the defendants. In addition to the fraudulent claims, the defendants were also found to have paid kickbacks for Medicare/Medicaid patient referrals. The physician and one codefendant were sentenced to 5 years' incarceration and 3 years' supervised release and were ordered to pay restitution totaling $8,715,896. The remaining six codefendants in the case all signed plea agreements and entered guilty pleas.

In Tennessee, a physician was found guilty of committing 50 counts of health care fraud and 45 counts of making false statements relating to health care matters. It was found that the defendant submitted false claims, misrepresented services, upcoded claims, and billed for services not rendered. Information received from a managed care organization affiliated with the Tenn-Care Medicaid program showed that, over a 4-year period, the defendant fraudulently billed approximately $1 million and was paid about $560,000. The case was a joint investigation conducted by the Tennessee Medicaid Fraud Bureau, HHS OIG, the FBI, the Tennessee Valley Authority, the U.S. Postal Inspection Service, and Blue Cross Blue Shield of Tennessee. The defendant was sentenced to 41 months in Federal prison and ordered to make restitution of $3,183,710. Of this amount, $1,818,650 was to be paid to Tenn-Care Medicaid. In addition, a special assessment fee of $9,500 was also ordered. Upon release from prison, the defendant was to be placed on supervised release for a period of 3 years.

In Delaware, a physician and his wife pled guilty to falsifying business records. The charges resulted from the MFCU's investigation into the physician's billing practices over a 2-year period. The investigation revealed that the physician's medical practice repeatedly and improperly billed Medicaid and Medicare for laser therapy supposedly performed by the physician, but actually performed by the physician's wife and other staff members. Claims were also submitted for massage therapy supposedly performed by the physician, when in fact the services were performed by massage therapists. Both defendants were sentenced to 1 year in prison with suspended probation. They were also ordered to pay $25,000 in restitution to both the Medicaid and Medicare programs.

Psychiatrist

A former New York psychiatrist was sentenced to more than 10 years in prison and ordered to make restitution in the amount of $309,000 to the Medicaid program for selling and distributing thousands of prescriptions for dangerously addictive drugs. The defendant and 33 other individuals were indicted and charged with numerous crimes, including counts alleging the criminal sale and possession of controlled substances, grand larceny, and conspiracy. The defendant/psychiatrist admitted to unlawfully selling to Medicaid recipients thousands of prescriptions for anti-depressants and narcotic drugs, including OxyContin, Percocet, and the anti-anxiety drug Xanax. The defendant was a key member of the conspiracy to defraud the Medicaid program and traffic in diverted medications worth millions of dollars on the street. This was a 16-month joint investigation conducted by the MFCU in cooperation with the New York City Police Department's Narcotics Division; the Human Resources Administration's Bureau of Controlled Substances; the New York State Police; the Department of Health's Bureau of Controlled Substances; and HHS OIG.

Psychologist

In Minnesota, one unlicensed psychologist contracted by the State to perform psychological services was charged with one count of theft by swindle, seven counts of theft by false representation, and one count of misrepresentation as a psychologist. After a week long trial, the defendant was found guilty on two counts: theft by swindle of more than $35,000 and misrepresentation as a licensed psychologist. The defendant was sentenced to 27 months' incarceration (sentence deferred) and placed on probation for 20 years. The conditions of the probation were that the defendant serve 90 days in jail, pay restitution in the amount of $39,697.48, perform 160 hours of community service, and pay a fine of $500 and a fee of $165.

Transportation

In New Hampshire, a transportation company agreed to pay $120,000 to settle allegations that over a 4-year period it inflated mileage claims when servicing Medicaid recipients, which resulted in overbilling the State's Medicaid program. The MFCU filed the complaint against the company under the State's false claims act. In addition to the settlement, the company also entered into a corporate integrity agreement with the Office of the Attorney General that strictly regulated the company's billing and record-keeping practices, and provided sanctions for any future violations.

In Colorado, a cab driver pled guilty to one count of theft, a class four felony, and one count of forgery, a class five felony. The defendant submitted forged trip vouchers to his employer cab company for trips that never occurred. The cab company paid the defendant for the supposed trips, and in turn billed Medicaid based on the forged vouchers. The defendant was ordered to perform 8 years of community service, was ordered to make restitution in the amount of $33,579.40.

Other Cases

In New York, a settlement was reached with a Brooklyn diagnostic and treatment center involving false claims submitted to Medicaid. The treatment center fraudulently billed the Medicaid program for services provided at its 25 part-time clinics. Under State regulations, part-time clinics affiliated with a major health care facility are not allowed to provide more than 60 hours of services per month to Medicaid recipients. The Brooklyn treatment center was found to have committed gross violations of the 60-hour limitation. As part of the settlement, the treatment center admitted that it had knowingly operated its 25 clinics in violation of the 60-hour limitation, and that it wrongfully sought payment from Medicaid for the services provided. Moreover, the center's director and its vice president pled guilty to third-degree grand larceny for knowingly causing the center to submit thousands of reimbursement claims for therapy and counseling services that were provided in excess of the 60-hour limitation. The treatment center agreed to repay $6 million to the Medicaid program.

In Maine, the bookkeeper of a nursing home was convicted of three counts of theft by deception. The defendant intentionally caused the Medicaid program to reimburse her for her own personal expenses, such as clothing and other items and services. The court sentenced the defendant to concurrent sentences on all three counts. The defendant was ordered to serve 60 days in jail with all but 15 days suspended and 1 year of probation. She was ordered to make full restitution to the Medicaid program of $4,534.25 and pay a $1,000 fine.

In Missouri, a speech therapist pled guilty to three counts of Medicaid fraud for submitting false claims for services that were not provided. The defendant was given 60 days of confinement and placed on supervised probation for 5 years. A sentence of 4 years in prison on each count, concurrent, was suspended pending the defendant's successful completion of probation. The defendant was ordered to pay $105,210 in restitution to the Medicaid program and investigative costs totaling $5,625.

Case Narratives FY 2005

The following are examples of Medicaid fraud and patient abuse and neglect case investigations and prosecutions conducted by MFCUs in FY 2005.

Billing

In Oregon, members of a family were convicted of aggravated theft and forgery in a scheme that defrauded the State's Medicaid program of more than $240,000 over a 5-year period. The defendants were the adoptive family of a medically fragile child who required intensive in-home nursing care. In the scheme, false timesheets bearing the forged signatures of the child's attending nurses were submitted to Medicaid for payment. The timesheets showed more hours than the attending nurses actually worked. The defendants deposited the Medicaid payments into their personal bank account, used their personal checks to pay the nurses for the actual hours they worked, and pocketed the difference. Each defendant was sentenced to 5 years' probation, and held liable to make full restitution to the Medicaid program.

Clinics

In Louisiana, a husband and wife who operated a children's well-care clinic were convicted on nine counts of Medicaid fraud and one count of felony theft. The husband was also convicted of money laundering in excess of $100,000. The pair submitted numerous false billings to Medicaid for nursing and nutrition consultation services that were not provided. From March through September 2001, the clinic was paid over $400,000 for screening and consultations that never occurred. The husband was sentenced to 50 years of imprisonment on the money laundering charge, a consecutive 5 years for committing Medicaid fraud, and a consecutive 10 years on the felony theft count. He was also ordered to make total restitution of $380,342 and pay investigative costs in the amount of $7,993. His wife was sentenced to 5 years for Medicaid fraud and a consecutive 10 years for the theft.

In Tennessee, a health care clinic pled guilty to charges of fraud and money laundering in connection with billing TennCare Medicaid for medically unnecessary specialized tests. The court ordered the clinic to pay restitution of $1,157,000 to the Federal Government and $43,000 to TennCare Medicaid. In addition, the clinic was excluded from participation in Medicare, Medicaid, and all other Federal health care programs.

Dentist

In Kentucky, a dentist who used untrained personnel to perform services and often used unsterilized equipment was convicted of two counts of Medicaid fraud and two counts of submitting false claims to Medicaid. He was sentenced to serve 2 years in prison and lost his license to practice. The defendant was also ordered to pay $180,000 in restitution, $16,000 in investigative costs, and a $2,000 criminal fine.

Durable Medical Equipment

In Michigan, criminal charges of obtaining money under false pretenses were filed against a DME supplier and its three owners. The case involved fraudulently billing Medicaid for surgical hosiery furnished to Medicaid beneficiaries, when in fact beneficiaries received compression hosiery. Medicaid reimburses the cost of compression hosiery at a lower amount than surgical hosiery. The monetary damages awarded to Medicaid were $1.1 million. All defendants were convicted and sentenced to 24 months' probation. A judgment in the amount of the fraud was also entered in a companion civil case.

In Oklahoma, the owner of a DME company pled guilty to health care fraud and causing a criminal act. The defendant filed false certification of medical necessity forms. He forged doctors' names on the forms required to receive electric wheelchairs valued at $5,000. The defendant furnished Medicaid recipients with scooters that were valued at only $1,500. The defendant was sentenced to 5 months' imprisonment, 3 years of supervised release, and 5 months of home confinement. He was also ordered to make restitution to the Medicaid program in the amount of $348,771.

Hospital

In New York, a $76.5 million settlement was reached with a university hospital. The MFCU investigation revealed that the hospital had for several years overbilled the Medicaid program for services provided at some of its part-time clinics, and that it submitted inaccurate cost report data, which caused Medicaid to pay inflated reimbursement rates for patient visits to its part-time clinics. Even though the hospital had been repeatedly warned by its own attorneys that these practices were illegal, the MFCU investigation disclosed that the hospital misled the State's Department of Health (DOH) by operating 21 of its part-time clinics well in excess of the 60-hour limitation set by the State, and improperly billed Medicaid for services rendered at an enhanced rate.

The MFCU investigation further revealed that hospital executives and executives of an affiliated company submitted inaccurate financial information and documents to DOH certifying the set rate that clinics would receive. As a result, the hospital and the affiliated company received millions of dollars that neither was entitled to receive.

Laboratory

In New Hampshire, a Rhode Island-based laboratory agreed to pay the State of New Hampshire $384,000 to settle allegations that it improperly billed Medicaid for urinalysis drug testing. Based on its investigation, the MFCU asserted that the laboratory had charged the Medicaid program for higher-cost "quantitative testing" on specimens when the tests performed were more akin and appropriate to "qualitative testing" which costs less. The MFCU also asserted that the lab had conducted confirmatory tests using a method that was not substantially different from the initial test, and in doing so improperly charged Medicaid for the cost difference. A final claim was that the laboratory routinely billed Medicaid at a rate higher than it billed its other customers in violation of the State's "usual and customary" law which is intended to secure the best rate available in the State.

Mental Health Services

In Washington, the owners of a mental health facility were convicted on five counts of theft in the first degree and were sentenced to 30 days in jail for defrauding the Medicaid program. Specifically, the owners billed Medicaid for counseling sessions to pregnant teenagers that did not occur. The defendants were ordered pay over $25,000 in restitution and $1,100 in court costs.

Nurses/Nurses Aides

In Kentucky, a licensed practical nurse was convicted of committing a torturous act on a mentally disabled male in a health care facility and was sentenced to serve 5 years in prison with no chance of probation. In addition, the defendant's nursing license was revoked and the defendant was permanently excluded from working in the health care field.

In Montana, a certified nursing assistant (CNA) was sentenced to 5 years, suspended; ordered to pay restitution of $10,000; and fined $1000 for exploiting an elderly female resident at the nursing home where she worked. The defendant pled guilty to one count of theft by common scheme, a felony. The CNA used her position at the nursing home and her relationship with the resident to financially exploit the resident's husband. Because the couple died prior to the defendant's conviction, restitution was made to their estate.

Patient Abuse and Neglect

In Alabama, a CNA was found guilty of reckless abuse of a protected person, a class C felony. The defendant's negligent actions caused a 91-year-old hospice patient to fracture her leg. At the time of the incident, the defendant was found to have a blood alcohol level of 0.248. The defendant was sentenced to 1 year and 1 day imprisonment, which was suspended for 2 years of supervised probation. The court also ordered the defendant to complete an alcohol treatment program, and banned the defendant from working in any nursing home or other long term care facility.

In Missouri, the manager of a group home pled guilty to involuntary manslaughter and admitted to recklessly causing the death of a resident. The defendant admittedly failed to make adequate provisions for the appropriate treatment of the resident's decubitis ulcers. The victim, who was confined to a wheelchair, had cerebral palsy and was physically and mentally handicapped. At the time of the incident, the resident was admitted to the hospital for treatment of the ulcers, but died. The defendant was sentenced to 5 years in prison. Charges of involuntary manslaughter in the first degree and resident neglect were also brought against the company that operated the group home and are pending.

In Rhode Island, a licensed practical nurse (LPN) working in a long term care facility was found to have intentionally refused to give the medications nitroglycerin and Mylanta to a patient. When the patient was found to be unresponsive, she was transported to a hospital where she later died. At no time did the LPN call for assistance from the registered nurse supervisor or the doctor on duty. The court accepted a nolo contendere plea from the LPN to abuse charges. The defendant received 2 years' probation and a suspension of her license for 2 years.

In Vermont, a licensed nursing assistant was charged with and convicted of assisting a male nurse in the sexual abuse of patient in a nursing home. The victim of the assault is a quadriplegic who is incapable of communication due to the paralysis. The nursing assistant disclosed that the male nurse had in the past sexually abused other residents of the facility and had implicated the defendant (the nursing assistant) as an accomplice. After being interviewed by police, the male nurse committed suicide. The defendant was sentenced to 1 to 2 years in jail, but was ordered to serve only 3 months of that term, with the remainder of the sentenced on probation. Special conditions of the defendant's probation required that the defendant get sexual offender counseling and treatment. The State also suspended the defendant's nursing assistant license.

Patient Funds

In Iowa, the son of an elderly beneficiary, acting as power of attorney for his mother, was ordered to repay the Medicaid program the full amount he stole from his mother's bank account, which totaled $34,217. By exploiting the funds for his own use, the court found that the son had violated Iowa Code 249F. His unlawful act resulted in the transfer of assets, which forced his mother to apply for and receive Medicaid benefits.

In Nevada, an employee of an assisted living facility was convicted of one count of felony theft from an elderly victim. In the course of her duties, the defendant collected checks from four elderly females at the facility and diverted the funds for her own use. Although the defendant was originally charged with four separate counts of theft, she agreed to plead to a single count involving the theft of four checks, which totaled $2,020. The defendant was sentenced to serve 12 to 60 months in prison, and ordered to pay $8,143 in restitution and submit to DNA sampling.

In New Hampshire, the son of an elderly man who resided in a nursing home was convicted of theft by misapplication. The son stole more than $33,000, which was derived from his father's Social Security and pension incomes. The defendant, who had power of attorney for his father's finances, stole the money after being notified that the income must be used for his father's nursing home care in accordance with Medicaid's cost-sharing rules. The defendant received a 12-month jail sentence and was ordered to make full restitution.

In North Carolina, the administrator of a health care center was convicted of embezzling over $70,000 from the center's patient trust fund account. A joint investigation conducted by the MFCU and the local police department revealed that the defendant deposited residents' checks into the trust fund and then moved the funds into a petty cash account from which she wrote checks to herself, her husband, and a friend. To disguise the transactions in the center's records, the defendant made false credit postings to the patients' accounts. The defendant was sentenced to 60 months of supervised probation and ordered to pay full restitution.

In Oklahoma, an administrator of a residential care facility pled guilty to six counts of felony caretaker exploitation. The defendant managed the facility's patient trust accounts, and in this capacity cashed Social Security checks of some of the residents. She used the residents' funds for her personal use to purchase items such as cameras and clothing. The defendant was sentenced to a 5-year deferred sentence on each count to run concurrently. She was also ordered to make restitution of $30,592 and pay court costs of $2,474.

In Tennessee, a coordinator in charge of a residential program for the mentally disabled was found guilty on 13 counts of theft of over $500. The court sentenced the defendant to serve 6 months in a Department of Corrections facility. The defendant was also ordered pay restitution in the amount of $28,690.86 to the 13 victims.

Pharmacies/Pharmacists

In South Carolina, a pharmacy chain entered into a settlement agreement to repay the Medicaid program $2,291,930 for excessive billings. The pharmacy chain failed to treat Medicaid as the payer of last resort, as the regulations require. The Medicaid program paid claims for prescription drugs that other third party payers should have paid either in full or proportionately. The settlement included a provision requiring that the chain's billing staff receive additional training in Medicaid claims processing to ensure that the Medicaid program in the future is recognized and treated as the payer of last resort. The pharmacy chain was also required to pay $150,000 in investigative costs to the MFCU.

In North Carolina, a pharmacist/pharmacy owner was found to have fraudulently billed the State's Medicaid program for over $2 million. A 5-year review of the pharmacy's billing data revealed that the pharmacist had filed approximately 39,000 false claims to Medicaid for prescriptions that were never filled. Upon conviction, the defendant was sentenced to 33 months in prison and ordered to pay restitution in the amount of $2,066,300 to Medicaid.

In Florida, a pharmacy owner pled guilty to defrauding the Medicaid program of $400,000 over a 5-month period. The MFCU investigation revealed that the defendant had billed Medicaid for a series of expensive AIDS medications. In many instances, the AIDS patients either received no medications at all or received incorrect medications, which greatly endangered their health. The defendant was placed on 2 years' house arrest, followed by 3 years' probation. The court ordered the defendant to pay restitution in the amount of $406,000 and investigative costs of $66,000, and to perform 300 hours of community service as a condition of probation.

Physicians

In Oregon, a physician accused of billing Federal health care programs, specifically Medicare and Medicaid, for drugs received as free samples from manufacturers agreed to resolve the matter by entering into a compliance program that required him to pay restitution, fines, and penalties of up to $213,198.

In Pennsylvania, a medical doctor pled guilty to six charges of violating the Pennsylvania Controlled Substance Act and four counts of attempting to commit Medicaid fraud. The MFCU investigation found that the defendant wrote prescriptions for drugs such as Percocet without conducting examinations or medical tests. On one occasion, the defendant wrote a prescription for an individual who never visited his office. An individual simply had to report a pain complaint to the defendant to get the specific prescription that he/she desired. The defendant was sentenced to 3 to 10 years in prison and was ordered to pay $13,950 in investigative costs. In addition, he was required to surrender his medical license, his Drug Enforcement Administration license, and his Medical Assistance Provider contract.

In Utah, a doctor pled guilty to one count of health care fraud for billing for services not covered by Medicare, Medicaid, or private insurers. The defendant was charged in Federal court with 58 counts of filing false claims. He was ordered to repay $145,616.24 in restitution, surrender his license, and was placed on 36 months' supervised release. HHS OIG, the MFCU, and the U.S. Attorney's office jointly conducted the case.

Psychologist

In Indiana, a psychologist employed unlicensed individuals to provide testing/counseling services to patients. He billed Medicaid for the services they performed as if they were licensed. The psychologist also billed Medicaid for services that were not performed. He was convicted of Medicaid fraud and sentenced to 36 months' imprisonment. He was also ordered to pay restitution in the amount of $291,427 to the Medicaid program.

Transportation

In Missouri, a nonemergency medical transportation company agreed to pay $2.4 million to settle allegations that it billed Medicaid for services not rendered, billed for more services than were provided, and breached its Medicaid contract with the State. The MFCU investigation revealed that the provider billed for trips its own records indicate were never provided, billed for more trip miles than were actually driven, and intentionally breached its contract with Medicaid by submitting claims in excess of the reimbursement rate agreed to in the contract. In addition to the $2.4 million settlement, the provider agreed to stop seeking approximately $17.4 million from Medicaid for claims that were denied or that it asserts were underpaid. The provider also agreed not to resubmit or appeal any of the claims that were denied as a result of its conduct.

In Ohio, the MFCU obtained 20 convictions against various ambulette company operators. An ambulette is a specially equipped wheelchair van. The investigation revealed that while the fraud committed by the operators had many variations, their most common fraudulent practice was to routinely transport by wheelchair patients who were fully capable of sitting in a regular passenger seat, and then bill the Medicaid program for wheelchair transport services. In addition to the convictions, the ambulette operators and their companies were also ordered to make restitution of nearly $1.7 million.

Other Cases

In Alaska, a coordinator working in a Medicaid-supported facility pled guilty to one count of medical assistance fraud for failing to provide records requested by the State's Medicaid agency. Despite several requests by the Medicaid agency and a demand by the MFCU investigator for the records, the defendant refused to furnish the requested records. The defendant was unaware of a law that made it a criminal offense to refuse to relinquish records to State officials upon request. The defendant was arrested and issued a citation. The defendant was sentenced to 30 days in jail, suspended, 2 years' probation, and ordered to perform 40 hours of community service.

In Florida, a settlement agreement was reached in April 2005 between the State, the Federal Government, and a Florida university in connection with false claims made to the Medicaid program from January 1996 through December 2002. During that period, the university acted on its own and on behalf of and in concert with other health care providers to knowingly submit claims to Medicaid for a 510-facility fee that was not covered under the provisions of the State's Medicaid program. The settlement reached was approximately $3.8 million.

In New Hampshire, an incorporated podiatry practice pled guilty to a Medicaid fraud scheme that yielded $18,330. Over several years, the company filed more than 80 fraudulent claims seeking reimbursement from Medicaid for orthopedic devices furnished to beneficiaries. Under the scheme, the defendant altered its invoices to falsely represent what it paid for the devices. The altered invoices caused Medicaid to pay the defendant $285 for each device, when it was only entitled to receive $78, the amount it actually paid for each device.

In addition to the criminal conviction, the defendant/company and its owner agreed to a civil settlement that required payment of an additional $40,000 for the civil penalties assessed and to payment of investigative costs relating to the scheme. The owner was terminated as a Medicaid provider.

Questions and comments regarding this report should be directed to:

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