

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF INSPECTOR GENERAL**



**State Medicaid Fraud Control Units  
Annual Report  
Fiscal Year 2008**

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## **Summary**

This is the 18th Office of Inspector General (OIG) Annual Report on the State Medicaid Fraud Control Units (MFCU). This report covers Federal fiscal year (FY) 2008, commencing October 1, 2007, and ending September 30, 2008.

During this reporting period, 49 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 varies from State to State. Forty-three of the MFCUs are located within Offices of State Attorneys General. The remaining seven MFCUs are located in various other State agencies.

In FY 2008, MFCUs recovered more than \$1.3 billion in court-ordered restitution, fines, civil settlements, and penalties. They also obtained 1,314 convictions. MFCUs reported a total of 971 instances in which civil settlements and/or judgments were achieved. Of the 3,129 OIG exclusions from participation in the Medicare, Medicaid, and other Federal health care programs in FY 2008, 755 exclusions were based on referrals made to OIG by the MFCUs.

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## **State Medicaid Fraud Control Units Annual Report for Fiscal Year 2008**

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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. Federal and State governments share in the cost of providing services to eligible Medicaid beneficiaries. The Federal share of Medicaid expenditures is calculated using the Federal medical assistance percentage rate established for each State, as well as Federal matching funds of 50 percent or more for various categories of administrative costs. Federal grant awards made to the Medicaid Fraud Control Units (MFCU) are generally funded on a 75-percent matching basis, with the States contributing the remaining 25 percent.

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 for correcting them. OIG's duties are carried out through a nationwide network of audits, investigations, evaluations, and other mission-related functions. OIG's Medicaid Fraud Policy and Oversight Division, contained within the Office of Evaluation and Inspections, is responsible for overseeing the activities of the 50 MFCUs.

The Omnibus Budget Reconciliation Act of 1993, section 13625, as codified in section 1902(a)(61) of the Act, requires OIG to develop performance standards for assessing MFCUs. This section also requires all States to operate MFCUs or receive waivers 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 MFCUs and to determine whether they are carrying out their duties and responsibilities in an effective and efficient manner.

## **Certification/Recertification**

Each State establishing a MFCU must submit an initial application for certification to the Secretary of HHS. A State must meet several major requirements to obtain both Federal certification and grant funding for the proposed MFCU. Notably, two regulatory requirements are especially critical when acquiring Federal certification: 42 CFR § 1007.5, which states that a MFCU “. . . must be a single, identifiable entity of the State government . . .” and 42 CFR § 1007.13(a), which states that a MFCU:

. . . must 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 1 year.

For an established MFCU to continue receiving Federal certification and grant funding from HHS, it must submit the required reapplication documents and an annual report 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 submitted material and determines whether the MFCU fully complied with the 12 MFCU 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. In addition, as part of the recertification process, OIG also evaluates the results of any onsite reviews that were conducted during the previous certification period. Once all submitted information is reviewed and assessed, the MFCU is notified in writing that its application for recertification is approved or denied.

## **Surveillance and Utilization Review Subsystems**

The State Medicaid agencies, with a few exceptions, are required to maintain Medicaid Management Information Systems (MMIS). The MMIS is a claims payment and information retrieval system. A vital part of the MMIS is the Surveillance and Utilization Review

Subsystem (SUR/S). The 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 Medicaid fraud.

Most MFCUs rely on referrals from the Medicaid agencies and/or the SUR/S to initiate many of their case investigations. When providers with aberrant patterns or practices are identified by the SUR/S, the information should be made available to the MFCU. Also, a MFCU is required to enter into a Memorandum of Understanding (MOU) with its respective State Medicaid agency. The MOU is intended to: (1) facilitate the referral of all suspected cases of provider fraud from the State Medicaid agencies to the MFCUs and (2) facilitate the routine exchange of information between the MFCUs and the State Medicaid agencies. Cooperation between these entities is essential to fostering a more efficient process of identifying and prosecuting fraud in the States' Medicaid programs.

## **Grant Expenditures**

In FY 2008, HHS awarded MFCUs more than \$184 million in Federal grant funds. The number of individuals employed by MFCUs in FY 2008 was 1,851. Since the inception of the Medicaid fraud control grant program in FY 1978, Federal grants awarded to MFCUs have totaled more than \$2.3 billion.

## **Accomplishments**

Collectively, in FY 2008, the 50 MFCUs obtained 1,314 convictions. Also in FY 2008, the MFCUs claimed total recoveries of more than \$1.3 billion in court-ordered restitution, fines, civil settlements, and penalties. Of the 3,129 OIG exclusions of individuals and entities from participation in Medicare, Medicaid, and other Federal health care programs in FY 2008, 755 were based on referrals made to OIG by MFCUs. The number of MFCU civil settlements and/or judgments achieved totaled 971.

Statistical information alone does not reflect the full measure of the MFCUs' accomplishments. 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 vulnerable beneficiaries.

In addition, MFCUs routinely engage in other noteworthy endeavors that are difficult to quantify. Such endeavors include: (1) presenting proposals to State legislatures that will benefit the Medicaid program; (2) making recommendations to State Medicaid agencies to effect positive change to Medicaid policies and regulations; and (3) participating in joint case investigations/prosecutions involving both Federal and State law enforcement agencies, as well as other State and local agencies.

## **Case Narratives**

The following are examples of Medicaid fraud and patient abuse and neglect case investigations and prosecutions conducted by MFCUs in FY 2008.

### **CERTIFIED NURSE ASSISTANTS**

In Maine, a certified nursing assistant (CNA) pled guilty to theft by unauthorized taking or transfer, was sentenced to 4 years' imprisonment with all but 12 months suspended and 2 years of probation with conditions, and was ordered to pay restitution. While employed as a CNA at a nursing facility, the defendant stole credit cards from a 97-year-old resident who was in ill health and embarked upon a shopping spree of over 100 transactions in a 2-month period. The defendant's spouse, who had been previously employed as a Certified Residential Medication Aide at the same facility, also pled guilty to theft by unauthorized taking or transfer. He was sentenced to 3 years' imprisonment with all but 3 months suspended and 2 years of probation with conditions and was ordered to pay restitution.

In Utah, a CNA employed at a rural care center pled guilty to attempted sexual battery, a class B misdemeanor. While working with another care provider at the care center, the CNA engaged in inappropriate touching and examination of a female resident's genitalia and made an inappropriate remark about its appearance. He was sentenced to 180 days in jail, of which he served 10 days, and was ordered to undergo a psychosexual evaluation and comply with other terms and conditions of probation. The defendant's certification as a nurse assistant was revoked and his record of conviction submitted to OIG for exclusion.

### **DENTISTS**

In North Carolina, a group of Medicaid dental service clinics reached a settlement agreement of \$10 million in restitution, interest, and penalties. The settlement resolved allegations (1) that the dental service clinics submitted claims to the North Carolina Medicaid Program for services that were not medically necessary or were performed in a manner that did not meet professionally recognized standards of care and (2) that in some cases, the clinics failed to obtain informed consent from parents for medical procedures and services. The defendants were the highest billers in the State for pulpotomies and stainless steel crowns. The investigation also revealed that young children were strapped into papoose boards and received 10 to 16 stainless steel crowns in one visit. As a result of the billing practices of the dental service clinics, the North Carolina Medicaid Program established a reimbursement limit of six stainless steel crowns per appointment. In addition, the two dentists were disciplined by the North Carolina Board of Dental Examiners.

## **DRUG-RELATED OFFENSES**

In Pennsylvania, a pharmacist was convicted of one count of mail fraud and one count of illegal distribution of scheduled narcotics. This plea followed an investigation that revealed that he was selling Oxycontin to patients without a prescription and billing the Pennsylvania Department of Public Welfare for prescriptions that were not authorized by a physician. The defendant was sentenced to 57 months' imprisonment and ordered to pay restitution in the amount of \$683,001, which included \$73,732 of restitution payable to the Pennsylvania Medicaid Program.

A Pennsylvania physician and his wife were both sentenced to 18 to 36 months' imprisonment followed by several years of probation after pleading guilty to delivery of a controlled substance by the practitioner, dispensing of drugs to a dependent person, Medicaid fraud, and related offenses. The doctor and his wife wrote prescriptions for Oxycontin in the name of the wife's mother, who was a resident of a nursing home and a patient of the doctor. The wife, who had a history of drug addiction, filled the prescriptions for her own use. After several months of paying cash for the prescriptions, the couple paid for the last 31 prescriptions with the mother's medical assistance benefits. The cost to the medical assistance program was \$17,000.

In Utah, a CNA trainee was charged with unlawful possession of a controlled substance, a third-degree felony, after it was discovered that she convinced a nursing home resident to exchange the resident's prescribed pain medication (Lortab) for cigarettes. The defendant pled guilty as charged to the offense and her plea was held in abeyance for 18 months, during which time she will undergo drug treatment assessment and comply with probationary terms.

In Vermont, a registered nurse pled guilty to one count of obtaining a regulated drug by deceit and one count of false statement in records, both felonies. The nurse admitted to routinely removing Schedule II and III narcotics from starter packs dispensed to patients being discharged from the hospital Emergency Department. The nurse was ordered to make donations totaling \$1,500 to a community mental health service provider and \$1,500 to a law enforcement training program on drug diversion crimes, to perform community service, and to pay restitution and court costs.

In Vermont, a licensed practical nurse pled guilty to one count of obtaining a regulated drug by deceit, a felony, and one count of abuse of a vulnerable adult, a misdemeanor. The defendant stole liquid Oxycodone belonging to an 87-year-old woman and then diluted the narcotic with cranberry juice, depriving the resident of her necessary pain medication, which caused the resident increased pain and other symptoms. The investigation captured the defendant's crimes on video surveillance. The defendant was sentenced to 6 months' imprisonment.

## **DURABLE MEDICAL EQUIPMENT COMPANIES**

In Colorado, the owner of a wheelchair repair and supply company pled guilty to felony theft, forgery, and organized crime; was sentenced to 10 years' imprisonment and 5 years' parole; and was ordered to pay restitution in excess of \$1 million. The defendant oversaw and submitted

hundreds of fraudulent Medicaid claims for power wheelchair repairs that either were not made or took only a small fraction of the time claimed. Company employees generated internal corporate documents that purported to show repairs, often forging the signature of the disabled recipients on the corporate forms. The defendant also ran a scheme in which wheelchair parts prices were inflated or billed when the parts were not provided. In addition, the company manager and two other employees pled guilty to their roles in the scheme and the manager was sentenced to 5 years' imprisonment.

In Oregon, the owner of a durable medical equipment company was convicted on three counts of making a false claim for health care payment. A joint MFCU/HHS-OIG investigation established that the defendant obtained fraudulent Certificates of Medical Necessity (CMN) and submitted the CMNs to federally funded health care programs to obtain payments for wheelchairs and accessories that were not ordered by the treating physicians or delivered to the beneficiaries. The defendant was sentenced to serve 20 days in jail and 3 years of probation on the condition he cooperate fully with State investigators and agree to a polygraph examination. He was also ordered to perform 480 hours of community service. Additionally, the defendant agreed to pay \$72,635.08 in restitution and to execute a lien on his homes.

### **HOME HEALTH SERVICES**

In Minnesota, coowners of a private duty nursing agency billed the Department of Human Services (DHS) for registered nurse services when there was no registered nurse on staff, billed DHS for registered nurse services when the services were provided by a licensed practical nurse, billed for unqualified workers for whom no background studies had been conducted, and billed for services that had not been rendered or lacked the required documentation. One defendant pled guilty to theft by swindle and the other pled guilty to criminal neglect. Each defendant was ordered to pay restitution in the amount of \$75,000, to devote 180 days of the sentence to a service program, and to pay a \$100 fine. Supervised probation was ordered for the principal owner for 10 years with the second defendant receiving 2 years.

In New York, following a multiyear investigation and audit, the former owner, president, and sole shareholder of a home health agency pled guilty to grand larceny in the third degree. The defendant admitted to giving his spouse a no-show job and submitting to the New York State Department of Health a certified home health agency cost report that falsely stated that the costs of his spouse's salary were related to the provision of patient care services, causing Medicaid to pay money to which the company was not entitled. The MFCU also obtained from the home health agency, which employs thousands of workers and serves patients in the New York metropolitan area and Long Island, a \$19.7 million settlement that resolved overbilling allegations. The defendant was sentenced to a conditional discharge and ordered to pay restitution in the amount of \$212,118 and penalties of \$424,236. The defendant is now barred for life from participating in the Medicaid and Medicare programs.

In Ohio, a husband and wife adopted several special needs children, each of whom qualified for home health services through the Medicaid program. Over a period of years, the couple hired a number of independent home health aides to provide these services and manipulated these independent providers in a scheme to defraud Medicaid. The husband and wife formed a corporation, required each of the independent providers to submit their claims for reimbursement through the corporation, and required the providers to have all of their Medicaid reimbursement payments directly deposited into an account in the name of the corporation. Unknown to the independent providers, the defendants then submitted claims to the single State agency for twice the value of the home health services actually rendered and kept the difference for themselves. The couple were each convicted of one count of theft, sentenced to 5 years of community control, and ordered to pay restitution in the amount of \$206,655.

In Oregon, a resident was convicted on 12 felony counts of making false claims for health care payment and 12 felony counts of theft in the first degree. A joint Federal-State investigation established that neighbors had agreed to a scheme whereby one individual would pretend to be disabled and the other would claim to be providing in-home caregiver services, reimbursed by the State Medicaid program. For 7 years, during an annual Medicaid assessment, the neighbors reported that the designated disabled neighbor was unable to bathe, toilet, cook meals, or even walk without substantial assistance from a caregiver. A year-long investigation revealed that the pretending party was not only capable of doing all these activities, but in fact raised sheep, bottle-fed calves, and rode horses on a weekly basis. The neighbors billed the State Medicaid Program for phantom services provided by the fraudulently designated caregiver and split the Medicaid payments received, which totaled in excess of \$100,000. The defendant designated as the caregiver was sentenced to 39 months' imprisonment and ordered to pay compensatory fines and restitution totaling \$108,225.33 and to write a letter of apology to the Oregon Department of Human Services, which administers the State's Medicaid Program. The defendant designated disabled was also charged in the case, but she died before trial and the charges were dismissed. The case was investigated by the MFCU, local caseworkers, and Federal agents from the HHS-OIG and the Social Security Administration.

In Washington, an in-home care provider pled guilty to three counts of theft in the first degree and five counts of Medicaid false statements. The defendant billed for services that were supposed to be provided to her mother when in fact the in-home care provider lived in another county. The defendant was sentenced to 25 months in prison on the theft counts, 12 months in prison on the false statement counts, and 12 months' probation upon release and was ordered to pay restitution in the amount of \$99,433.09.

## **HOSPITAL**

In New York, the MFCU reached a settlement with a Staten Island University Hospital (SIUH) and SIUH Systems, Inc., resolving a whistleblower lawsuit alleging that the systems company defrauded the Medicaid program. Under the terms of the settlement, the company will return \$24,806,471 to Medicaid. The settlement resolved allegations that SIUH Systems knowingly presented, or caused to be presented, false claims to Medicaid for reimbursement for inpatient

detoxification treatment provided in a special unit within the hospital for which the company had not obtained a certificate of operation from the State. The settlement is the result of a joint investigation conducted by the MFCU and the United States Attorney for the Eastern District of New York into allegations made by a physician who formerly worked at the systems company. The doctor filed a “whistleblower” complaint under the New York False Claims Act, which authorizes persons who have uncovered fraud against the State to file a civil action against the alleged wrongdoer and come forward with information about the false claims to the New York State Attorney General’s Office.

### **MANAGED CARE PROVIDER**

In New York, following an intensive multiyear investigation, the MFCU reached a \$35 million settlement with the largest Medicaid managed care provider in the State. The MFCU’s investigation centered on the provider’s practice of compensating its marketing representatives based on productivity, in violation of its contracts with State and local government agencies, and the company’s false statements to those agencies about its marketing practices. The managed care provider violated its Medicaid managed care contract by paying bonuses or other compensation incentives to its employees based on the number of people it enrolled from 1999 to September 2003. The company also filed marketing plans with New York City and the New York State Department of Health, as well as local social services districts in Nassau and Suffolk Counties, which falsely represented that its marketing representatives were compensated based solely on qualitative criteria, when its bonuses and other compensation incentives were based on productivity. By this conduct, it violated the integrity of the enrollment process. The managed care provider, which cooperated with the MFCU, disclosed matters concerning improper compensation practices and enrollment fraud committed by certain of its former marketing representatives. It also replaced its senior management by hiring a new president, chief executive officer, and chief operating officer. The criminal case is currently pending.

### **MENTAL HEALTH SERVICES**

In Delaware, a psychiatric nurse assistant was convicted of sexual relations in a detention facility, a felony, and abuse of an infirm adult, a misdemeanor. The investigation revealed that the defendant engaged in sexual intercourse on two separate occasions with a 23-year-old female patient who had a lengthy history of mental illness. The defendant was sentenced to 60 days’ imprisonment, followed by 6 months of home confinement and 1 year of intensive probation. In addition, as a result of this conviction, the defendant will be automatically disqualified from working in any licensed health care facility for 10 years.

In Delaware, a psychiatric nurse assistant employed by the Delaware Psychiatric Center was convicted of assault in the third degree and reckless endangering in the second degree. The defendant punched a male patient who had a lengthy history of mental illness. The patient was being maintained on supervision for continuous aggressive behavior. When two female staff members became concerned for their safety because of the victim’s behavior, the defendant and another male nurse assistant intervened to assist. During this intervention, the defendant punched

the victim, causing him to sustain a fractured jaw. The defendant was sentenced to 1 year of intensive supervised probation and ordered to have no contact with the victim. Additional conditions of the sentence included an agreement to a lifetime placement on the adult abuse registry maintained by the Department of Health and Social Services and restitution to the victim for medical expenses.

In the District of Columbia, the owner of a mental health clinic pled guilty to making a false statement to Medicaid. The defendant submitted claims to Medicaid asserting that he provided mental health services and received payments exceeding \$500,000 for services not rendered. The defendant was sentenced to 20 months' imprisonment and 2 years' supervised probation upon release and forfeited cash and bonds.

In Maryland, a husband and wife were each sentenced to 2 years' incarceration and ordered to pay restitution to the State Medicaid Program in the amount of \$783,653 as a result of their convictions for conspiracy, felony Medicaid fraud, and theft. The evidence in the case established that the wife, a licensed social worker, and her husband, who handled her billing, submitted thousands of false claims to the Maryland Medicaid program for therapy services that were not performed or were different from the services billed for. The wife billed for services she claimed to have performed on several days when she was a hospital inpatient. She also billed for 9 months of multiple therapy services a week for a patient she never saw and who was in the hospital at the time the services were allegedly rendered. The State established that Medicaid paid the couple nearly \$900,000. Although required to do so by the Medicaid regulations, they failed to document over \$700,000 of those services.

In Pennsylvania, a behavioral specialist consultant/mobile therapist was sentenced to 1 year of intermediate punishment with the following conditions: 90 days to be served in 45 weekends, 624 hours of community service, and 3 months of home monitoring consecutive to the 90-day sentence. He was also sentenced to 12 years of consecutive probation and was ordered to pay \$52,695 in restitution and \$151 in prosecution costs. The charges of Medicaid fraud, theft by deception, forgery, and tampering with public records arose out of a presentment issued by the Statewide Investigating Grand Jury. The grand jury found that the defendant was working for various medical assistance providers and had submitted timesheets showing that she had seen more than one client on the same date and at the same time.

## **NURSING SERVICES**

In Arizona, the office manager of a nursing home management company in Phoenix pled guilty to diverting money from the firm for her personal use. An audit of the company determined that the defendant altered computer records and submitted requests to the corporate office for payments in the names of friends, family, and other seemingly legitimate payees. The defendant was sentenced to 2½ years' imprisonment after pleading guilty to an amended theft charge and ordered to pay restitution in the amount of approximately \$204,000.

In Maine, a registered nurse employed at three long-term care facilities diverted and tampered with morphine and other narcotics belonging to elderly residents of those facilities. Laboratory analysis of physical evidence revealed significant dilution of residents' liquid morphine with water and, in one instance, the substitution of hydroxyzine and meclizine. The defendant pled guilty to two counts of stealing drugs and five counts of felony endangering the welfare of a dependent person and was sentenced in two criminal actions. The nurse received concurrent sentences on all counts of 4½ years' imprisonment with all but 2½ years suspended and 2 years of probation with conditions. A \$400 fine was also imposed.

In New York, a 60-year-old who worked as a volunteer at a health center in Syracuse was charged with three counts of sexual abuse in the third degree, a class B misdemeanor; three counts of endangering the welfare of an incompetent or physically disabled person, a class A misdemeanor; and public lewdness, a class B misdemeanor. The charges stemmed from the defendant's interactions with three of the facility's female residents. The defendant pled guilty to endangering the welfare of an incompetent or physically disabled person. The defendant was sentenced to 60 days' incarceration and 3 years' probation. One of the terms of his probation requires him to undergo mental health counseling.

In Ohio, an independent home health nurse authorized to provide skilled nursing services to a Medicaid patient came to the attention of the MFCU when the single State agency discovered that her claims for reimbursement for these services averaged 96 hours per week. The MFCU's investigation revealed that, in addition to rendering home health services under an independent provider agreement, the defendant was employed as a nurse by an area hospital and that many of the hours she claimed for reimbursement overlapped hours she worked at the hospital. The nurse was convicted of one count of Medicaid fraud. The defendant was sentenced to serve 5 years of community control and ordered to pay restitution in the amount of \$113,463.80 and investigative costs of \$8,000. In addition, her nursing license was revoked by the Ohio Board of Nursing.

In Ohio, an independent home health nurse authorized to provide skilled nursing services to several Medicaid patients knowingly submitted claims for reimbursement for services that were not provided and failed to code certain claims under a group rate when simultaneously providing services to more than one patient. In furtherance of this scheme, she falsified nursing notes to make it appear as though she had provided home health services when she had not. The defendant was convicted of one count of Medicaid fraud and one count of theft. The defendant was sentenced to serve 4 years of community control and was ordered to pay restitution in the amount of \$108,399.16. The defendant subsequently appealed her conviction, which was affirmed by the Court of Appeals.

## **OCCUPATIONAL THERAPIST**

In Pennsylvania, an occupational therapist was convicted of one count of Medicaid fraud, a felony in the third degree. While working as an occupational therapist, the defendant billed for services not rendered. The defendant pled guilty and was sentenced to 23 months' probation and ordered to pay restitution to the Pennsylvania Department of Public Welfare, Medical Assistance Program, in the amount of \$29,433.

## **PATIENT ABUSE**

In Ohio, a nursing assistant employed by a nursing facility struck an elderly resident in the face for failing to cooperate with efforts to provide care. As a result of this incident, the defendant was discharged from the facility and subsequently secured employment at a nursing facility in a neighboring county. He committed several additional acts of abuse shortly thereafter. The defendant was convicted of three counts of patient abuse and was sentenced to serve 4 years' imprisonment.

In Vermont, a licensed mental health counselor was convicted of two counts of abuse of a vulnerable adult. The counselor admitted that while employed at an inpatient facility that treats women and adolescents who suffer from drug and alcohol dependency, she commenced a sexual relationship with a resident she was treating for severe alcoholism. She continued the sexual relationship even after the resident's discharge from the facility and, as a result, the resident's rehabilitative and therapeutic efforts were severely compromised. The defendant received a sentence of 18 months' to 2 years' imprisonment and was ordered to pay restitution in the amount of \$7,505 to the Medicaid Program.

## **PATIENT FUNDS**

In New York, an assisted living facility employed an individual to assist the facility's elderly and infirm residents in paying their bills and conducting financial transactions on their behalf. Instead of assisting the residents, the defendant used a variety of deceptions to steal more than \$350,000. Over the course of 2 years, the defendant convinced residents to sign blank checks, claiming that she would fill in the rest to pay the residents' bills. Instead, she made checks payable to herself or to "cash" and either cashed or deposited the checks into her own account. She also stole blank checks from one resident and later duped the resident into endorsing them. Additionally, the defendant used a resident's credit card to make ATM withdrawals and to make purchases at The Gap, Toys 'R Us, and Shell Oil. The defendant pled guilty to grand larceny in the second degree, a class C felony; was sentenced to 1 year of imprisonment; and was ordered to pay restitution in the amount of \$343,130.

In North Carolina, a former accounts receivable clerk admitted to taking money from the facility's patient fund account and manipulating the facility's patient rosters to conceal the embezzlement. The investigation revealed a total of 165 forged patient trust fund checks resulting in \$262,984.91 of embezzled funds. The defendant pled guilty to one count of embezzlement in connection with health care; was sentenced to 24 months and 1 day imprisonment and 2 years of supervised probation; and was ordered to pay \$262,984.91 in restitution, a \$100 court assessment fee, and court-appointed counsel fees.

In Oregon, a program manager for adult living group homes, a Medicaid-funded facility for developmentally disabled individuals, was convicted on charges of theft in the first degree and criminal mistreatment in the first degree. The MFCU investigation established that the defendant had misappropriated the funds of three developmentally disabled clients in the group home,

totaling \$4,542.70, and had stolen another \$718 from her employer at a nursing home. The defendant was sentenced to serve 30 days' imprisonment and 3 years of probation and was ordered to (1) pay full restitution, (2) not be employed in any capacity paid with Medicaid or Medicare dollars, (3) not be employed in any capacity in which she has access to elderly or dependent persons, and (4) perform 480 hours of community service.

In Oregon, the MFCU secured the conviction of the former business manager of a nursing home on six counts of theft in the first degree and four counts of forgery in the first degree. The defendant was sentenced to serve 20 months in prison and ordered to pay full restitution in the amount of \$122,412.30. The corporation, which owns Newport Rehabilitation and Specialty Care, Inc., contacted the MFCU alleging that the defendant had misappropriated funds at the facility. A MFCU investigation established that the defendant stole \$122,412.30, primarily by altering corporate books to hide client and Medicaid fund payments and then forging company checks made payable to herself. The defendant used the stolen money to finance a gambling addiction.

### **SPEECH PATHOLOGIST**

In Kentucky, a speech pathologist who contracted with an early intervention program to provide services to children 3 years of age and under billed for services not rendered. Following the plea to the charge of bribing a witness, the defendant pled to the indictment and was sentenced to 1 year of imprisonment on each count, running concurrently, and was placed on probation for 5 years on the conditions that she not participate in a Federal health care program, pay restitution, and pay investigative costs.

### **TRANSPORTATION**

In New York, the MFCU's investigation of a transportation company that offered taxi and ambulette services to Medicaid recipients revealed that its owner and president submitted false reimbursement claims to Medicaid stating that the company complied with Medicaid and State motor vehicle regulations when, in fact, the company's drivers failed to meet minimum qualifications to provide services (an ambulette provides emergency or nonemergency transportation and paramedic services to those who are sick or injured). Because of the false claims filed by the company, Medicaid paid \$971,267 to which the company was not entitled. The investigation also found that one of the ambulette drivers was involved in an accident while transporting an elderly wheelchair-bound patient and ran from the accident scene, abandoning the patient. The owner and president was aware of the accident but filed an annual affidavit of compliance with the New York State Department of Motor Vehicles stating that none of the company's drivers had been involved in any accidents. The company and owner pled guilty to stealing \$971,267 from Medicaid and agreed to pay full restitution. The company, which pled guilty to grand larceny in the second degree, was fined \$10,000 and ordered to pay restitution in the amount of \$971,267. The owner, who pled guilty to grand larceny in the third degree and offering a false instrument for filing in the first degree, was sentenced to 2 to 6 years' imprisonment. The court also ordered the owner to repay the \$971,267.

In Ohio, transportation providers are authorized to receive reimbursement for ambulette transports only when the patient is transported in a wheelchair in an ambulette vehicle, as licensed by the Medicaid Transportation Board. The owner and operator of a transportation service knowingly submitted claims for reimbursement of ambulette services for Medicaid patients who were not transported in wheelchairs or in licensed ambulette vehicles. The defendant was convicted of nine counts of health care fraud, sentenced to serve 5 months' imprisonment in a Federal prison, and ordered to pay restitution in the amount of \$202,393.32.