Prosecuting Medicare Fraudsters: Lessons Learned from Recent Litigation

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The researchers investigated the 41 appellate cases of Medicare fraud that were decided by the 11 circuits of the United States Court of Appeals during the past three years (January 2014 through December 2016). A study of those cases led to these conclusions: (1) the crimes for which Medicare fraudsters are most often prosecuted are healthcare fraud, conspiracy to commit healthcare fraud, payment of kickbacks, and identity theft; (2) Medicare fraudsters were personnel in all aspects of healthcare; (3) types of Medicare fraud included overbilling for services and billing for services to fake patients; and (4) Medicare fraud convicts received variable prison sentences.

INTRODUCTION

The easy money accessible through Medicare fraud continues to be a temptation for those in the health services industry. The objectives of this study are to: (1) investigate the 41 appellate cases of Medicare fraud that were decided by the 11 circuits of the United States Court of Appeals during the past three years (January, 2014 through December, 2016); (2) to determine the crimes for which Medicare fraudsters are most often prosecuted; (3) to discover which types of healthcare professionals are the common participants in Medicare fraud; (4) to define the most common types of Medicare fraud schemes; and (5) ascertain the sentences ordinarily meted out to those convicted of Medicare fraud.

THE RELEVANT CRIMINAL STATUTES

During the past three years, Medicare fraudsters have been most commonly prosecuted for violation of these federal criminal statutes:

Healthcare Fraud: 18 U.S.C. Sect. 1347. The elements are knowingly and willfully (1) executing a scheme or artifice to defraud any healthcare benefit program; or (2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any healthcare benefit program, in connection with the delivery of or payment for healthcare benefits, items or services. (United States v. Megwa)

Conspiracy to Commit Healthcare Fraud: 18 U.S.C. Sect. 1349. The elements are: (1) two or more persons made an agreement to commit healthcare fraud; (2) they knew the agreement had an unlawful

purpose; and (3) they joined in the agreement willfully, that is, with the intent to further the unlawful purpose. (United States v. Megwa)

Making False Statements Relating to Healthcare Matters: 18 U.S.C. Sect. 1035. The elements are: (1) the making of a materially false statement; (2) in connection with the delivery of or payment for healthcare benefits; (3) in a matter involving a healthcare benefit program, as that term is defined in 18 U.S.C. Sect. 24(b); and (4) acting knowingly and willfully. (United States v. Perry)

Aggravated Identity Theft: 18 U.S.C. Sect. 1028A(a)(1). The elements are: (1) knowingly transfer, possess, or use; (2) without lawful authority; (3) a means of identification of another person; and (4) during and in relation to a predicate felony offense such as healthcare fraud. (United States v. Perry)

Payment of Kickbacks to Patients or Patient Recruiters: 42 U.S.C. Sect. 1320a-7b. The elements are: (1) knowingly and willfully; (2) offer, pay, solicit or receive; (3) remuneration, in cash or in kind; (4) to induce or in return for referring an individual for the furnishing or arranging of any item or service; and (5) for which payment may be made under a federal healthcare program. (Social Security Act)

CATEGORIES OF HEALTHCARE

Professionals Convicted of Medicare Fraud

During the past three years, Medicare fraudsters have included home healthcare firms, physician house call firms, nursing homes, physicians of several specialties (general practice, dermatology, gastroenterology, and podiatry), nurses, pharmacists, physical therapists, and psychologists.

Types of Medicare Fraud, With Cases

Overbilling Physician House Call Patients. Dale St. John founded A Medical, a physician house call company, in 2009. Physician house call companies help homebound patients regain mobility. St. John hired Dr. Nicholas Padron, a physician. A Medical defrauded Medicare by billing at least $30,000 per week, irrespective of whether the firm had performed services costing that amount. Patients were recruited by home healthcare firms and brought to Dr. Padron for certification for Medicare benefits. Dr. Padron certified 99% of the patients brought to him for his consideration. A Medical submitted requests for reimbursement for services it never performed and defrauded Medicare out of $9 million. St. John was convicted of Healthcare Fraud and Conspiracy and sentenced to 10 years in prison. (United States v. St. John)

Overbilling Physical Therapy Patients. One of the most egregious cases of massive fraud was orchestrated by Umawa Imo, the owner of an alleged physical therapy clinic in Houston, Texas. He hired Catherina Clardy, a medical doctor who allegedly supervised the physical therapy, and Kenneth Anokam, a physical therapy aide. This firm would only accept Medicare patients. During a patient's first visit, an employee would collect basic medical information from the patient and would have the patient sign numerous blank treatment forms. The firm's employees would later fill in these forms, regardless of whether the patient actually received any treatment. Over a three-year period, this firm submitted claims to Medicare totaling more than $30 million. During the investigation of the fraud, it was discovered that on one of the days, this small firm submitted claims for 380 patients! Imo, Clardy, and Anokam were convicted of Healthcare Fraud and Conspiracy. Imo, as the owner of the firm and the ringleader of the conspiracy, was sentenced to 27 years in federal prison, Clardy received a sentence of 11 years, and Anokam received 12 and-a-half years. (United States v. Imo)

In another similar case, a firm ostensibly providing physical therapy services for homebound patients bilked Medicare out of millions of dollars. The firm used the Medicare numbers, personal information and signatures of customers fraudulently to bill for in-home health care that was never provided. In exchange, the customers got cash or drugs. The three conspirators were convicted of Healthcare Fraud and Conspiracy and were sentenced to more than six years in federal prison. (United States v. Patel)

Overbilling Home Healthcare Patients. A home healthcare provider, CPC, was owned and managed by Wayne Perry. He was assisted by his wife, Angela. CPC routinely billed during 2009-2013 for the maximum number of personal care hours authorized by a patient's Plan of Care, rather than by the

number of hours documented on its employees' timesheets, as required by the government. One CPC employee raised concerns about this practice with the firm's owner and manager after taking a Medicare college course. When the employee spoke with Angela, she responded, "That is what Wayne wants us to do, so that's what we do." To conceal the fraud, Wayne directed his employees to change the records and forge signatures if necessary. Despite his best efforts at concealment, the fraud was eventually uncovered. Mr. and Mrs. Perry were convicted of healthcare fraud, conspiracy, making false statements, and alteration of records. After a jury trial, they were sentenced to federal prison. (United States v. Perry)

In a similar case, a home healthcare provider recruited patients and then exaggerated their medical conditions on the Medicare OASIS form and its manager signed it. Next, the firm hired a medical doctor to sign Form 485, the Medicare form pertaining to the Plan of Care for treating the patients' medical conditions. The physician, Dr. Joseph Megwa, never saw any of the patients at any time, before or after signing the form. Nevertheless, Dr. Megwa was responsible for his part in the fraud scheme and was convicted of healthcare fraud, conspiracy to commit healthcare fraud, and giving false statements pertaining to healthcare matters. (United States v. Megwa, Note 1 at 1-2, 8-10)

In another similar case, Dr. Ben Echols authorized home healthcare for patients he had not seen or treated. Dr. Echols was medical director of two home healthcare agencies, Family Home Healthcare and Houston Compassionate Care. Rather than receiving physician referrals, these two firms recruited Medicare beneficiaries by asking if they were interested in home healthcare services. Both companies then asked the patients' primary care doctors to sign the Medicare Plan of Care forms. If the physicians refused, the two firms' employees took the forms to Dr. Echols for his signature. Echols signed the forms without asking questions, requesting the patients' files, or making any changes—even though many of the firms' forms listed other doctors' names. Doctors listed on the claims signed by Echols testified that they had not authorized home healthcare. Family and Compassionate paid Echols $1,500 and $700 per month, respectively, in his capacity as medical director. The two firms' employees usually brought Echols checks or cash for payment when they brought the forms for his signature. In all, Family and Compassionate paid Echols more than $100,000. In his defense, Dr. Echols testified that he acted in good faith and wrongly trusted that what Family, Compassionate, and their employees asked him to do was legal. However, the jury did not accept this defense. Echols was convicted of Conspiracy to Commit Healthcare Fraud and six counts of making false statements in connection with the delivery of or payments for healthcare benefits, items or services. Taking into account that Dr. Echols' unlawful acts resulted in a loss of $2.9 million, he was sentenced to five years in federal prison. (United States v. Echols)

Billing for Services on Fake Patients Procured by Identity Theft. Jose Lopez-Dias and Carlos Lopez-Diaz were brothers living in Puerto Rico. Jose was a medical doctor and Carlos was a dentist. Carlos gave Jose access to his dental patients' billing records. Jose billed Medicare for services to Carlos' patients that Jose never provided and had never even seen! This is a case of unbridled greed. Between January 2006 and July 2011, Jose submitted 10,231 claims for reimbursement to Medicare, totaling $3.5 million, of which Medicare actually paid about $700,000. In some instances, Jose claimed to have provided medical services to Medicare beneficiaries who were deceased. He repeatedly billed for the same unusual procedures. Jose filed 1,177 claims (far more than anyone else in Puerto Rico) for a procedure typically performed by urologists, and more than half of those claimed urological procedures were for female patients even though the procedure can be performed on male patients only! Sheer stupidity. (United States v. Lopez-Diaz)

The jury convicted Jose of Healthcare Fraud, Conspiracy to Commit Healthcare Fraud, and Aggravated Identity Theft for using personal information gathered from Carlos' patients. He was sentenced to 10 years in federal prison. (United States v. Lopez-Diaz)

Massive Fraud Through Kickbacks Paid to Actual Medicare Patients. Gustave Drivas was the president and owner of several medical clinics in Brooklyn, New York that fraudulently billed Medicare for $70 million in medical services and tests that were never performed, medically unnecessary, or performed poorly by unlicensed individuals. Drivas was a medical doctor and certified that the Medicare applications were truthful and correct, notwithstanding the fact that he never saw any patients during the period of the unlawful activity. Drivas hired a number of fake, unqualified "doctors" to work in his

clinics. His fakes billed Medicare for more than 30,000 office visits and for tens of thousands of services purportedly rendered to patients. (United States v. Wahl)

In order to increase the number of the clinics' "patients," they were paid kickbacks even though they had nothing wrong with them. The clinics paid out as much as $12,500 per day in kickbacks to their patients, and a queue would occasionally form outside of the room in which kickbacks were distributed. The clinics emphasized the recruitment of Russian immigrants; a poster was placed in the kickback distribution room in which a woman appeared to "shush" the viewer, with the phrase "Don't Blab" printed in Russian. (United States v. Wahl)

Drivas was convicted of Healthcare Fraud and Conspiracy to Commit Healthcare Fraud. Because the federal sentencing guidelines mete out harsher penalties if the fraud is massive, Drivas was sentenced to 12 years in federal prison. (United States v. Wahl)

Other Medicare fraud cases involving kickbacks include: (a) United States v. Tran, infra; (b) United States v. Vega, infra; and (c) one in which an Assistant Hospital Administrator, in a conspiracy with his employer hospital's owners and operators, paid kickbacks for recruitment of patients and paid kickbacks to the patients themselves. Medicare was billed for $116 million in fraudulent claims for mental health treatment ostensibly given to patients who did not need such treatment. The administrator admitted that he knew that some of the services being billed by the hospital were not medically necessary or were never provided. He was convicted for Conspiracy to Commit Healthcare Fraud and was sentenced to an undisclosed term in federal prison. (United States v. Khan)

Fake Prescriptions and Selling Drugs on the Street. A physician, Dr. Carl Fowler, and a podiatrist, Dr. Anmy Tran, entered into an unlawful agreement with Babubhai Patel, the owner of several pharmacies and home healthcare providers in Detroit. Fowler and Tran wrote fake prescriptions for controlled substances, some of which were billed to Medicare and private insurers and some of which were sold on the black market. Patel paid kickbacks to managers of health-related companies so that they would send patients to his pharmacies, and he employed "marketers" to recruit fake "patients" directly from the streets. Pharmacists facilitated the criminal activity by charging insurers for expensive medications that were ordered from wholesale distributors and held in inventory but not dispensed to patients. These surplus medications were later returned to the supplier for credit or sold on the black market. (United States v. Tran)

Patel recruited Tran to participate in the conspiracy by initially paying her $50,000. Over the course of her participation in the conspiracy, she was instrumental in defrauding Medicare out of $4.5 million. Dr. Fowler's participation in the conspiracy resulted in defrauding Medicare out of $1.7 million. In separate trials, both were convicted of Healthcare Fraud, Conspiracy to Commit Healthcare Fraud, Conspiracy to Distribute Controlled Substances, and Conspiracy to Pay or Receive Healthcare Kickbacks. Tran was sentenced to five years in federal prison and Fowler was sentenced to six years. (United States v. Tran)

In a case similar to the Tran case, a medical doctor wrote prescriptions for fictitious patients and a conspiring pharmacy billed Medicare $753,430 for the drugs, but no drugs were ever issued. The medical doctor was paid $60,000 to write the fraudulent prescriptions. The pharmacist also established a medical clinic called Discovery Therapy, Inc. This clinic was designed to provide physical examinations, injections, and treatment for non-serious illnesses. Discovery became a licensed Medicare Part C provider. To bring in patients, recruiters would pay kickbacks to patients despite the fact they had no medical problems. The purpose of the fake patients was solely to defraud Medicare. Discovery did just that. During one 82-day period, Medicare paid the clinic $443,000. The pharmacist was convicted of Healthcare Fraud, Conspiracy, and Payment of Kickbacks, and was sentenced to 8-and-a-half years in federal prison. The pharmacist's wife and the Medicare doctor entered into plea agreements and were sentenced to two years in prison. (United States v. Sosa)

In another case, a pharmacist was convicted of Healthcare Fraud and for unlawfully possessing and distributing a controlled substance. He received consecutive sentences of five years in prison for the Healthcare Fraud and 19 years in prison for unlawful possession and sale of the drugs. (United States v. Ayika)

Selling Medical Equipment Not Medically Necessary. Vega was the director of Preferred Medical Equipment, a supplier of durable medical equipment such as wheelchairs, walkers, orthotics, and electric hospital beds. Ordinarily, a patient obtains such equipment from a firm such as Preferred upon the presentation of a physician's order. If the patient is a Medicare beneficiary, the firm can submit a claim to Medicare for partial reimbursement. The documentation must show the equipment is medically necessary and prescribed by a physician. Due to the volume of claims received, Medicare is unable to verify each claim before it pays. Vega took advantage of this situation by recruiting patients and telling them the equipment was free and by hiring a medical doctor to confirm that the equipment was medically necessary. Preferred submitted 95 false claims for $210,223.47 during the one-year period beginning in April 2010. For his role in the scheme, Vega was convicted of Conspiracy and Aiding and Abetting Solicitation and Receipt of Kickbacks. They were also convicted for Aiding and Abetting Aggravated Identity Theft because several claims were submitted after the persons had stated they did not want the equipment. Vega was convicted on all counts and sentenced to two years in federal prison and three years of supervised release. (United States v. Vega)

The Nursing Homes from Hell. George Houser owned three nursing homes, all of which were certified recipients of Medicare funds. The facilities' total capacity was 404 residents, and occupancy rates ranged between 75% and 90%. Of these residents, 90% had their care funded by Medicare. Under Medicare guidelines, the facilities were required to provide residents with a clean, safe, and sanitary environment to maintain or support the highest practicable level of physical and mental well-being to every resident. However, during 2003-2007, the three nursing homes were atrociously filthy and were later described as "barbaric" and "uncivilized." The roofs would leak and some of the ceilings fell in and damaged the residents' property. Houser was warned by his subordinates about these hazards, but he did nothing to rectify the situation. Often, there was insufficient heat during the winter and inadequate air conditioning during the summer. There were no cleaning supplies. The laundry facilities were often inoperable due to disrepair. Trash service was stopped due to Houser's failure to pay removal bills. Medications were not available for patients because Houser failed to pay the pharmacy. There was a shortage of staff and there was insufficient food. After being regularly cited for violations, the three nursing homes were closed. Prior to their closure, Medicare had paid $32.9 million to Houser for resident care. Houser was convicted of Healthcare Fraud, Conspiracy, Payroll Tax Fraud, and Failure to File Income Tax Returns. He was sentenced to 20 years in federal prison. (United States v. Houser)

Billing for "Psychotherapy" Conducted by Psychology Students. Dr. Keenan R. Ferrell was a professor of psychology at Roosevelt University in Chicago. He also held a license to practice psychology in the State of Illinois. In December 2000, he applied to become a provider in the Medicare program and was approved. He established two firms to provide psychotherapy to individuals and groups in nursing homes, rehabilitation facilities, and individual homes. During 2006-2011, Ferrell, Bryce Woods, and William Woods caused approximately 33,895 individual claims to be submitted to Medicare. Each claim listed Ferrell as the provider of the services. To lawfully qualify for Medicare reimbursement, a psychotherapy session had to be face-to-face, at least 45 minutes long, and personally conducted by a licensed psychologist or another licensee under Ferrell's supervision. Although aware of these requirements, Ferrell and his brother engaged in a scheme to bill Medicare for psychotherapy sessions that either did not occur, or did not meet the three requirements. Ferrell assigned his unlicensed psychology students at Roosevelt University to work for his two firms. These unlicensed students were assigned to patients and visited with patients who resided at nursing homes. Ferrell did not supervise these unlicensed students or otherwise visit the nursing homes. The unlicensed students prepared notes of their visits with patients, and give these notes and other documents to Bryce and William Woods. At Ferrell's direction, Bryce Wood billed Medicare for these visits. Similarly, Bryce Woods, who was not licensed to practice psychotherapy, would visit with patients at Ferrell's direction. Bryce Woods' sessions would sometimes include playing his guitar and singing to patients. Additionally, Ferrell and Bryce Woods sometimes billed Medicare for sessions less than 45 minutes, for sessions in which a patient refused to meet, and in a few cases when the patient was deceased. Altogether, the conspiracy billed for

$3.5 million and received $1.5 million from Medicare. Ferrell was convicted of Healthcare Fraud and sentenced to seven years in federal prison. (United States v. Ferrell)

CONCLUSIONS

The researchers investigated the 41 appellate cases of Medicare fraud that were decided by the 11 circuits of the United States Court of Appeals during the past three years (January 2014 through December 2016). A study of those cases led to these conclusions: (1) the crimes for which Medicare fraudsters are most often prosecuted are healthcare fraud, conspiracy to commit healthcare fraud, payment of kickbacks, and identity theft; (2) Medicare fraudsters included physicians in several specialties (general practice, dermatology, podiatry and gastroenterology), nurses, pharmacists, physical therapists, psychologists, nursing homes, physician house call firms, and home healthcare firms; (3) types of Medicare fraud include overbilling for services to actual patients (most often by home healthcare firms, physician house call firms or physical therapists), billing for services to fake patients procured by identity theft, payment of kickbacks to patients or to recruiters of patients, using fraudulent prescriptions to bill medicine to Medicare and to procure drugs for sale on the street, selling and charging for unnecessary medical equipment, billing for psychotherapy conducted by psychology students, and charging for nursing home services that are woefully inadequate; and (4) Medicare fraud convicts received variable prison sentences ranging from a few years to more than 20 years, depending on the amount of money defrauded, and were required to reimburse Medicare for the full amount of the fraud.

REFERENCES

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