Healthcare Fraud Investigations

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Abstract: *Tax healthcare fraud and tax evasion affects us all. It occurs within a country and across countries both within the EU,USA and globally. That is why a single country cannot solve the problem on its own. The EU and Member States need to work more together and internationally to combat the problem at home and abroad.*

Open dialogue involving the European Commission, stakeholders and interested parties helps ensure that existing rules and proposals for new rules are designed to keep pace with the reality of rapid change. This dialogue helps to achieve the regulatory efficiency we need to foster best administrative and legislative practice tailored to meet the needs of business in the European Union in the third millennium.

Key words:"Tax fraud", "tax evasion", "healthcare", "white-collar crime", "examples"

Health care fraud is a type of white collar crime that involves the filing of dishonest health care claims in order to turn a profit. Fraudulent health care schemes come in many forms. Practitioner schemes include: individuals obtaining subsidized or fully-covered prescription pills that are actually unneeded and then selling them on the black market for a profit; billing by practitioners for care that they never rendered; filing duplicate claims for the same service rendered; altering the dates, description of services, or identities of members or providers; billing for a non-covered service as a covered service;

modifying medical records; intentional incorrect reporting of diagnoses or procedures to maximize payment; use of unlicensed staff; accepting or giving kickbacks for member referrals; waiving member co-pays; and prescribing additional or unnecessary treatment. Members can commit health care fraud by providing false information when applying for programs or services, forging or selling prescription drugs, using transportation benefits for non-medical related purposes, and loaning or using another's insurance card.

The phrase "white-collar crime" was coined in 1939 during a speech given by Edwin Sutherland to the American Sociological Society. Sutherland defined the term as "crime committed by a person of respectability and high social status in the course of his occupation." Although there has been some debate as to what qualifies as a white-collar crime, the term today generally encompasses a variety of nonviolent crimes usually committed in commercial situations for financial gain. Many white-collar crimes are especially difficult to prosecute because the perpetrators use sophisticated means to conceal their activities through a series of complex transactions. The most common white-collar offenses include: antitrust violations, computer and internet fraud, credit card fraud, phone and telemarketing fraud, bankruptcy fraud, healthcare fraud, environmental law violations, insurance fraud, mail fraud, government fraud, tax evasion, financial fraud, securities fraud, insider trading, bribery, kickbacks, counterfeiting, public corruption, money laundering, embezzlement, economic espionage and trade secret theft. According to the Federal Bureau of Investigation, white-collar crime is estimated to cost the United States more than $300 billion annually. Although typically the government charges individuals for white-collar crimes, the government has the power to sanction corporations as well for these offenses. The penalties for white-collar offenses include fines, home detention, community confinement, paying the cost of prosecution, forfeitures, restitution, supervised release, and imprisonment. However, sanctions can be lessened if the defendant takes responsibility for the crime and assists the authorities in their investigation. Any defenses available to non-white-collar defendants in criminal court are also available to those accused of white-collar crimes. A common refrain of individuals or organizations facing white-collar criminal charges is the defense of entrapment. For instance, in United States v. Williams, 705 F.2d 603 (2nd Cir. 1983), one of the cases arising from "Operation Abscam," Senator Harrison Williams attempted unsuccessfully to argue that the government induced him into accepting a bribe.

Both state and federal legislation enumerate the activities that constitute white-collar criminal offenses. The Commerce Clause of the U.S. Constitution gives the federal government the authority to regulate white-collar crime, and a number of federal agencies (see sidebar), including the FBI, the Internal Revenue Service, the Secret Service, U.S. Customs, the Environmental Protection Agency, and the Securities and Exchange Commission, participate in the enforcement of federal white-collar crime legislation. In addition, most states employ their own agencies to enforce white-collar crime laws at the state level.

When a health care fraud is perpetrated, the health care provider passes the costs along to its customers. Because of the

pervasiveness of health care fraud, statistics now show that 10 cents of every dollar spent on health care goes toward paying for fraudulent health care claims.

Congressional legislation requires that health care insurance pay a legitimate claim within 30 days. The Federal Bureau of Investigation, the U.S. Postal Service, and the Office of the Inspector General all are charged with the responsibility of investigating healthcare fraud. However, because of the 30-day rule, these agencies rarely have enough time to perform an adequate investigation before an insurer has to pay.

A successful prosecution of a health care provider that ends in a conviction can have serious consequences. The health care provider faces incarceration, fines, and possibly losing the right to practice in the medical industry.

The following examples of healthcare fraud investigations are written from public record documents on file in the courts within the judicial district where the cases were prosecuted.

Former Office Manager/Bookkeeper Sentenced for Wire Fraud and Tax Evasion

On Sept. 25, 2014, in Columbia, South Carolina, Chandra Padgett, of Batesburg, was sentenced to 87 months in prison for her conviction on charges of wire fraud and tax evasion. According to court documents, Padgett was an office manager and bookkeeper for a pain clinic. Padgett set up a shell company named PSS (Padgett Specialty Scrapbooking Services). The name PSS was shared with her employer's primary vendor and allowed Padgett to send bogus invoices for payment. Between June 2008 and December 2010, Padgett created checks from her employer's account payable to her company PSS and deposited them in to an account to which she had primary control. Padgett also used her position as bookkeeper and office manager to increase her own salary without her employer's authorization or knowledge. Padgett was ordered to pay restitution to her employer and the Internal Revenue Service.

Nurse-CEO Sentenced for Health Care Fraud and Money Laundering

On Sept. 15, 2014, in Des Moines, Iowa, Angela Shae Ellison, of Centerville, Iowa, the former owner and CEO of Cornerstone Counseling Center, was sentenced to 12 months and a day in prison and ordered to pay $724,359 in restitution. Ellison previously pleaded guilty to charges of health care fraud and money laundering. According to court documents, Ellison, who previously worked as a nurse, orchestrated a fraudulent billing scheme in which she directed employees of Cornerstone Counseling Center to bill various insurance companies over 6,000 times using the names and national provider identification number of various doctors who did not perform the services for which the bills were submitted. Many of the fraudulent bills involved the name and identification number of a doctor who never performed any work for the Center. Over $1 million in bogus bills were submitted, and the various insurance entities paid out more than $700,000 in claims.

Owner of Tax Return Preparation Franchise and Health Provider Business Sentenced To Prison

On Sept. 11, 2014, in Greensboro, North Carolina, Claude Arthur Verbal II, formerly of Raleigh, North Carolina, and now of

Miami, was sentenced to 135 months in prison for tax fraud, healthcare fraud and money laundering crimes in two separate cases. Verbal was also ordered to serve three years of supervised release and to pay restitution of $4,078,584 to the Internal Revenue Service (IRS) and $2,382,378 to the North Carolina Department of Health and Human Services. On April 9, Verbal pleaded guilty to one count of conspiracy to defraud the United States, one count of aiding and assisting the preparation of false tax returns, one count of healthcare fraud and one count of money laundering. Verbal was the owner of Nothing But Taxes (NBT), that operated from 2005 to at least 2012. Verbal personally prepared false tax returns for clients and taught and encouraged his employees to do so as well. Verbal and employees frequently offered clients a dramatically larger tax refund if the client agreed to make a cash payment to their tax preparer over and above the flat return preparation fee that NBT charged every client, whether or not their return was falsified. In a separate case, Verbal was the owner and operator of Infinite Wellness Concepts (IWC), a Medicaid behavioral health provider with several locations in North Carolina. IWC was contracted to provide group therapy, intensive in-home services, and enhanced mental health and substance abuse services. Verbal acquired at least $1 million in fraudulently obtained funds from the Medicaid program. The money laundering charge to which Verbal pleaded guilty relates to the purchase of a $52,000 diamond ring with the proceeds of healthcare fraud.

Leader of $20 Million Fraud Scheme Sentenced on Conspiracy Charges

On Aug. 18, 2014, in Los Angeles, California, Lianna "Lili" Ovsepian, of Tujunga, was sentenced to 96 months in prison and ordered to pay $9,146,137 in restitution to Medicare and Medi-Cal. In November 2013, Ovsepian pleaded guilty to conspiracy to commit health care fraud and conspiracy to commit identity theft. According to court documents, Ovsepian was the manager and owner of Manor Medical Imaging, Inc., which generated thousands of fraudulent prescriptions for unneeded and expensive anti-psychotic medications for "patients" who were typically low-income beneficiaries of the government-funded health care programs Medicare and Medi-Cal, and who did not need those drugs. The beneficiaries who received the prescriptions were brought to pharmacies, where the prescriptions were filled. The drugs were returned to Manor, the "patients" were given nominal payments (usually around $100), and the drugs were diverted into the black market, where they were sold to other pharmacies and re-billed to health care programs as though the drugs were being dispensed for the first time. The beneficiaries included veterans recruited from dual diagnosis programs for drug addiction and schizophrenia, elderly Medicare beneficiaries whose identities were stolen and homeless beneficiaries recruited from skid row. From September 2009 through October 27, 2011, Medi-Cal and Medicare was billed more than $20 million, and the programs paid more than $9.1 million to pharmacies based on more than 14,000 claims submitted in relation to the scheme.

Chiropractor and Office Assistant Sentenced in Staged Automobile Accident Scheme

On Aug. 8, 2014, in Miami, Florida, Lawrence Schechtman, chiropractor, of Parkland, and Sircy Sacerio, aka "Sisi" aka "Sircy Santos", receptionist and office

assistant, of Palm Springs, were sentenced for their participation in an automobile insurance fraud scheme involving staged automobile accidents. Schechtman was sentenced to 52 months in prison, two years of supervised release and ordered to pay $2,446,906 in restitution. Sacerio was sentenced to 48 months in prison, two years of supervised release and ordered to pay $1,146,824 in restitution. Both previously pleaded guilty to conspiracy to commit mail fraud and mail fraud. According to court documents, between approximately October 2006 and December 2012, the conspiracy members staged automobile accidents by recruiting individuals to participate in the accidents. The clinic owners caused the submission of false insurance claims through chiropractic clinics that were controlled by members of the conspiracy. To execute the scheme, the true owners of the chiropractic clinics recruited individuals who had the medical or chiropractic licenses required by the state to open a clinic, including Schechtman, to act as "nominee owners" of the clinics. The co-conspirators also hired complicit licensed chiropractors, including Schechtman, who prescribed and billed for unnecessary treatments and/or for services that had not been rendered. Complicit clinic employees, including Sacerio, prepared and submitted claims to the automobile insurance companies for payment for these unnecessary or non-rendered services. Twenty-one clinics participated in this scheme. To date 92 defendants have been charged for their participation in the scheme.

New Jersey Doctor Sentenced for Accepting Bribes for Test Referrals

On July 7, in Newark, New Jersey, Dennis Aponte, of Cedar Grove, was sentenced to 24 months in prison, one year of supervised release, fined $50,000 and ordered to forfeit $235,000. Aponte, a doctor, previously pleaded guilty to violating the Federal Travel Act. According to court documents, Aponte accepted tens of thousands of dollars in bribes from Parsippany-based Biodiagnostic Laboratory Services LLC (BLS) as part of a long-running scheme operated by the lab, its president, and numerous associates. According to court documents, Aponte admitted that he and the BLS president, David Nicoll, agreed that BLS would pay Aponte bribes to refer to BLS blood specimens from the patients of his West New York, New Jersey medical practice. From October 2012 to March 2013, Aponte was paid approximately $3,000 per month in cash in return for blood specimens referred to BLS. The lab made more than $175,000 through testing on blood specimens referred by Aponte.

California Woman Sentenced in Health Care Fraud Scheme

On April 14, 2014 in Los Angeles, Calif., Susanna Artsruni was sentenced to 76 months in prison and ordered to pay $9,624,556 in restitution. Artsruni previously pleaded guilty to one count of health care fraud and one count of money laundering. According to court documents, Artsruni formerly owned a durable medical equipment (DME) company and worked at a number of medical clinics in Los Angeles. She orchestrated a scheme that submitted nearly $25 million in fraudulent bills to Medicare for services and supplies that were medically unnecessary and sometimes were never provided. In one part of the scheme, Artsruni had physician's assistants at three Los Angeles medical clinics

sign prescriptions and orders for medically unnecessary DME and diagnostic tests that were later referred to other Medicare providers that billed for the equipment and tests. Artsruni also caused the three clinics to bill Medicare for medically unnecessary services. Artsruni fraudulently billed Medicare on behalf of her own DME supply company, Midvalley Medical Supply in Van Nuys, for medically unnecessary DME based on referrals from one of the three medical clinics. In total, Artsruni caused more than $24.8 million in fraudulent claims to be submitted to Medicare, which paid more than $9.6 million on the bogus bills. In addition, Artsruni wrote checks totaling more than $35,000 from the Midvalley bank account to three corporations that had no connection to the medical industry. She wrote these checks to conceal the nature of the funds as the proceeds of health care fraud and used the three corporations to launder these funds.

Two Women Sentenced for Using Stolen Identities to Claim Millions from Medicaid

On April 9, 2014, in Charlotte, N.C., Victoria Finney Brewton, of Shelby, N.C., was sentenced to 111 months in prison, three years of supervised release and ordered to pay $7,070,426 in restitution to Medicaid and $573,392 to IRS. On April 8, 2014, co-defendant, Rodnisha Sade Cannon, of Charlotte, was sentenced to 102 months in prison, three years court supervised release and ordered to pay $2,541,306 in restitution. In January 2013, Brewton pleaded guilty to health care fraud and health care fraud conspiracy, aggravated identity theft and filing false tax returns. Cannon pleaded guilty in April 2013 to health care fraud conspiracy, aggravated identity theft, money laundering conspiracy and to attempting to remove property subject to seizure. According to court documents and court proceedings, from 2008 to 2012, Brewton operated a series of after-school and summer childcare programs in Shelby. Brewton recruited juvenile Medicaid beneficiaries through their families to sign up for these programs, promising the programs would be free for Medicaid recipients. Court records show that Brewton stole the Medicaid recipient numbers of some of the children and families who had signed up for the programs and fraudulently billed Medicaid for mental and behavioral health services which were never provided. Brewton was not a Medicaid-approved provider but submitted the fraudulent reimbursement claims through other Medicaid-approved providers, some of whom did not know their information had been compromised. Cannon initially worked as a patient recruiter for Brewton, providing Brewton with the personal information of Medicaid recipients, which Brewton then used to file fraudulent reimbursement claims with Medicaid. Cannon later began running her own similar health care fraud scheme, that attempted to defraud Medicaid in fraudulent reimbursement claims using the stolen identities of patients and therapists. In total, Cannon and her conspirators submitted approximately $4.8 million in false claims.

Brothers Sentenced for Health Care Fraud

On March 19, 2014, in Charleston, S.C., Truman Lewis, of Charlotte, and his brother Norman Lewis, of Georgetown, were sentenced for participating in a conspiracy to

commit health care fraud and money laundering. Truman Lewis was sentenced to 120 months in prison and Norman Lewis was sentenced to 90 months in prison. Both were ordered to pay $3,307,967 in restitution to Medicaid. According to trial evidence, Truman and Norman Lewis billed Medicaid for almost $9 million in a 22-month period, with much of the billing being fraudulent. The defendants ran a for-profit youth mentoring service called Helping Hands Youth and Family Services, which had offices in Georgetown, Conway, Rock Hill, and Columbia. The defendants billed for weekends when children were not seen, for periods of time before children were in the program, for periods of time after the children had left the program, and for children who had no diagnosis to justify billing.

Georgia Doctor Sentenced for Defrauding Medicare and IRS

On Feb. 20, 2014, in Atlanta, Ga., Lawrence Eppelbaum was sentenced to 50 months in prison and fined $3.5 million after a jury found him guilty on 27 counts of healthcare fraud, tax fraud and money laundering. According information presented in court, Eppelbaum is a physician who is licensed to practice medicine in Georgia and operates the "Atlanta Institute of Medicine and Rehabilitation" ("AIMR") and the "Pain Clinic of AIMR" in Atlanta. In 2004, Eppelbaum created the "Back Pain Fund," a purported charitable organization that he controlled both directly and indirectly. Eppelbaum, through the Back Pain Fund, paid for Medicare patients to travel to Atlanta to receive medical treatment from his practice, then travel to Florida to visit a local hot spring for approximately four days, before returning to Atlanta to receive additional treatment. Eppelbaum was the primary donor to the Back Pain Fund and paid the vast majority of its operating expenses. Eppelbaum tried to disguise his financial control over the Back Pain Fund by entering into an arrangement with a school in Atlanta, whereby the parents of students attending the school were instructed to make their tuition checks payable to the Back Pain Fund instead of to the school, and in turn, Eppelbaum repaid the school for the amount of the tuition, plus an additional 25 percent. Eppelbaum entered into similar arrangements with other organizations, and even caused patients who were treated at his medical practice to make their checks payable to the Back Pain Fund. Between 2004 and 2009, Eppelbaum treated hundreds of Back Pain Fund patients and received approximately $16 million for their treatment from Medicare. Eppelbaum also utilized the Back Pain Fund as a vehicle for committing tax fraud. Between 2006 through 2008, Eppelbaum deducted as charitable donations all the payments he made to the Back Pain Fund, the school and other organizations with which he had a financial arrangement, even though Eppelbaum derived substantial personal income from treating Back Pain Fund patients. Eppelbaum evaded approximately $1 million in federal income taxes through his scheme.

Wyoming Man Sentenced for Role in Healthcare Fraud

On January 27, 2014, in Cheyenne, Wyo., Paul D. Cardwell, of Tipton, Ind., was sentenced to 121 months in prison, three years of supervised release and ordered to pay

$1,698,644 in restitution. Cardwell pleaded guilty to conspiracy to commit mail and wire fraud and conspiracy to commit money laundering. Cardwell was arrested in Hua Hin, Thailand. According to court documents, Cardwell was the Chief Executive Officer (CEO) at Powell Valley Healthcare (PVHC), Inc. Beginning about March 2011 and continuing through September 2011, Cardwell and his co-defendant entered into a conspiracy to defraud PVHC of $847,884 through a fraudulent billing scheme.

Georgia Man Sentenced for Filing False Claims

On January 10, 2014, in Augusta, Ga., Jeffrey Sponseller was sentenced to 33 months in prison, three years of supervised release and ordered to pay $441,729 in restitution. Sponseller previously pleaded guilty to one count of false claims. According to court documents, Sponseller was an optometrist and owner of Eye Care One, a medical company which purportedly specialized in comprehensive vision care at nursing home facilities. On July 27, 2009 Sponseller visited a nursing facility and later submitted claims to Medicare for over $30,000 for 177 patients. From January 1, 2008 through February 24, 2011, Sponseller billed Medicare for more than $800,000. Many of these claims were false and fraudulent in that the specific health care services were not provided.

Defendant Sentenced for Structuring Monetary Transactions

On November 21, 2013, in Los Angeles, Calif., Theanna Khou, aka San Huy Khou, was sentenced to 12 months and one day in prison and three years of supervised release. Khou pleaded guilty in August 2013 to structuring monetary transactions to evade reporting requirements. According to court documents, Khou and a co-defendant owned and operated Huntington Pharmacy. Between approximately August 2009 and November 2009, Khou structured approximately $105,826 in cash deposits. The cash was proceeds from the sale of oxycontin that Huntington Pharmacy dispensed without medical necessity based on fraudulent prescription issued by a clinic. In addition, Khou entered into an agreement with others operating Manor Medical Imaging, Inc. to fill large volumes of prescriptions for anti-psychotic medications that were not medically needed. Khou, through Huntington Pharmacy, billed Medicare and Medi-Cal for the service of filling the prescriptions.

Owner of Home Health Companies Sentenced for Role in $20 Million Health Care Fraud Scheme

On November 21, 2013, in Miami, Fla., Roberto Marrero, of Miami, was sentenced 120 months in prison. In September 2013, Marrero pleaded guilty to conspiracy to commit health care fraud and conspiracy to receive and pay health care kickbacks. Marrero was an owner and operator of Trust Care, a Miami home health care agency that purported to provide home health and physical therapy services to Medicare beneficiaries. According to court documents, Marrero and his co-conspirators operated Trust Care for the purpose of billing the Medicare Program for, among other things, expensive physical therapy and home health care services that were not medically necessary and/or were not provided. Marrero was also responsible for negotiating and paying kickbacks and bribes, interacting with patient recruiters,

and coordinating and overseeing the submission of fraudulent claims to the Medicare program. Marrero and his co-conspirators paid kickbacks and bribes to patient recruiters in return for the recruiters providing patients to Trust Care. Marrero and his co-conspirators also paid kickbacks and bribes to co-conspirators in doctors' offices and clinics in exchange for home health and therapy prescriptions, medical certifications and other documentation. Marrero and his co-conspirators used these prescriptions, medical certifications and other documentation to fraudulently bill the Medicare program. From approximately March 2007 through at least October 2010, Trust Care submitted more than $20 million in claims for home health services. Medicare paid Trust Care more than $15 million for these fraudulent claims. Marrero and his co-conspirators have also acknowledged their involvement in similar fraudulent schemes at several other Miami health care agencies with estimated total losses of approximately $50 million. Co-conspirators Sandra Fernandez Viera, Patricia Morcate, and Enrique Rodriguez, all of Miami, pleaded guilty to related charges, including conspiracy to commit health care fraud and conspiracy to receive and pay health care kickbacks. On November 13, 2013, Fernandez Viera was sentenced to 120 months in prison; Morcate was sentenced to 60 months; and Rodriguez was sentenced to 57 months.

Prominent Cardiologist Sentenced for $19 Million Billing Fraud Scheme

On November 20, 2013, in Newark, N.J., Jose Katz, of Closter, N.J., was sentenced to 78 months in prison, three years of supervised release and ordered to pay $19 million in restitution. Katz, a well-known cardiologist and the founder, CEO and sole owner of two large medical services companies in New Jersey and New York, previously pleaded guilty to an information charging him with one count of conspiracy to commit health care fraud. He also pleaded guilty to one count of Social Security fraud arising from a separate scheme to give his wife a "no show" job and make her eligible for Social Security benefits. According to court documents, from 2004 through 2012, Katz conspired to bill Medicare Part B, Medicaid, Empire BCBS, Aetna and others for unnecessary tests and unnecessary procedures based on false diagnoses and for medical services rendered by unlicensed practitioners. Katz agreed that the loss amount sustained by Medicare, Medicaid and other insurers victimized by the fraudulent billings was $19 million. In addition, from 2005 through 2012, Katz kept his wife on Cardio-Med's payroll though she performed little or no work. During the course of the scheme, Katz sent false W-2 forms for calendar years 2005 through 2011 to the Social Security Administration purportedly reflecting $1,251,604 in earnings for his wife, making her eligible for an estimated $263,000 in Social Security benefits to which she was not entitled.

Indiana Woman Sentenced for State Medicaid Fraud and Failure to File Federal Taxes

On October 25, 2013, in Hammond, Ind., Regina Cabell, of West Lafayette, Ind., was sentenced to 18 months in prison, one year

of supervised release and ordered to pay $79,871 in restitution to the Indiana Medicaid Program. Cabell previously pleaded guilty to Medicaid fraud and failure to file a tax return. According to court documents, from about May 2010 through February 2012, Cabel, doing business as L&G Transportation, participated in a scheme to defraud the Indiana Medicaid Program by submitting false claims for providing transportation services to Indiana Medicaid recipients. Cabel submitted claims containing inflated mileage claims and/or transportation that did not actually occur. Further, during the calendar year 2011, Cabell, doing business as L&G Transportation, received gross income of $297,567. However, she willfully failed to file a tax return for the 2011 calendar year.

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