Introduction to Medicaid Fraud

Missouri Attorney General’s Office
Medicaid Fraud Control Unit

Updated June 2013
History of Medicaid Fraud Control Unit (MFCU) Program

- MFCUs were created in 1977 by the Medicare-Medicaid Anti-Fraud Amendment (P.L. 95-142).
  - Missouri’s MFCU was created in 1994.

- 49 States and D.C. have MFCUs
  - **North Dakota** is the only state that does not have a MFCU.
MFCU Jurisdiction

- **FRAUD**
  - Investigating and prosecuting fraud in the administration of the Medicaid program, the provision of medical assistance, or the activities of providers of medical assistance under the State Medicaid program. 42 C.F.R. §1007.11(a)
  - MFCUs also are authorized to investigate and prosecute fraud involving other federally funded healthcare programs where there is a Medicaid nexus. *Ticket to Work and Work Incentive Improvement Act* (1999) P.L. 106-170

- **ABUSE & NEGLECT**
  - The unit will also review complaints alleging abuse or neglect of patients in health care facilities receiving payments under the State Medicaid plan and may review complaints of the misappropriation of patient’s private funds in such facilities. 42 C.F.R. §1007.11(b)
  - MFCUs also have the option to investigate complaints of abuse or neglect of patients residing in board and care facilities (regardless of source of payment). *State Fraud Policy Transmittal No. 2000-1*, DHSS, (Sept. 20, 2000).
How Does MFCU Get Cases?

1. Referrals from Medicaid
   - The Medicaid program must refer all cases of suspected fraud to MFCU. 42 C.F.R. §455.21

2. Referrals from licensing boards

3. Referrals from other state agencies

4. Hotline Tips
   - Patients
   - Employee whistleblowers

5. Self-Generated Referrals
The Medicaid Program MUST...

- **REFER** all cases of suspected fraud to MFCU.

- **Provide MFCU with ACCESS to:**
  - Agency records;
  - Computerized data;
  - Info kept by providers which is accessible by the agency.

- **Initiate any available action to RECOVER improper payments upon referral from MFCU.**
MFCU Referrals

- FFY 2011
  - 240 Investigations
  - 147 Resolutions
- FFY 2012
  - 176 Investigations
  - 112 Resolutions
Investigative Checklist
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<th>Date Requested</th>
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<td></td>
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<td>1. Meet with attorney to discuss the complaint/referral.</td>
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<td>a. Determine whether complaint, on its face needs any preliminary investigation.</td>
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<td>2. Review complaint opening and file</td>
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<td>a. Determine the provider type</td>
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<td>b. Detail relevant portions of MHD Provider Manual &amp; Bulletins</td>
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<td>o Print relevant sections (e.g., 13, 19) of manual to case binder, including relevant provider bulletins.</td>
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<td>c. Review relevant state statutes</td>
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<td>d. Review the Code of State Regulations (CSRs) on Secretary of State website and detail relevant portions</td>
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<td>o Print relevant CSR provisions for case binder</td>
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<td>e. Contact the complainant, if necessary, to obtain additional information</td>
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<td>3. PI Request (MFCU Database)</td>
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<td>a. Request information from PI.</td>
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<td>b. Once you have received PI’s response, review the content. (A few things to look for: prior education, previous overpayment letters, banking information and provider communication logs).</td>
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<td>o Print relevant portions for case binder.</td>
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<td>4. Review claims summary and data for past three years</td>
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<td>a. Download Medicaid claims data and save in your H: drive</td>
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<td>b. Examine &amp; print provider summary chart, amount paid each year</td>
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<td>o Print relevant portions for case binder.</td>
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<td>c. Request specialized report, if applicable.</td>
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<td>d. Look for evidence of illegal scheme</td>
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<td>e. Review the Medicaid billings (e.g., top procedure codes billed and top recipients billed)</td>
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<td>5. Run MULES/Accurint on target</td>
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<td>a. Do a memo to file to interpret/summarize criminal history information through MULES</td>
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<td>o NOTE: MULES criminal history information is not to be disclosed to anyone outside of the AGO</td>
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<td>b. Use Accurint to do a memo to file, noting:</td>
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<td>o Property owned by target and assessed value</td>
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<td>o Liens/judgments against target</td>
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<td>o Professional licenses (note licenses in all states)</td>
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<td>o Other relevant information (if applicable)</td>
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<td>6. DOR Photos of all relevant individuals (e.g., target, witnesses)</td>
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<td>7. Professional Registration</td>
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<td>a. Search Professional Registration website to determine licensee status</td>
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<td>o Print relevant portions for case binder.</td>
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<td>b. Call for further discipline information</td>
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<td>c. If appropriate, request a copy of provider’s case file</td>
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<td>8. Check AHC opinions RE: target licensure discipline/overpayment disputes</td>
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<td>a. Search for AHC opinions re: target (request documentation, if applicable, &amp; request copy of file for binder)</td>
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<td>9. Employment Security</td>
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<td>a. Consult with Chief Investigator to determine appropriateness of Employment Security request</td>
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<td>b. To obtain individual employment security log into FAMIS and type IMES+SSN (print and put in case binder)</td>
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<td>Preliminary Information</td>
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|                         |                |                | c. Fax employment security request for records to Linda Hafley using one of the standard request forms (See H:\MFCU Library/Investigators)  
  - The form you use depends on whether the request is for an individual or a business.  
  - E.g., this could help you determine that an individual may be billing for personal care while working somewhere else (follow up to request employment files).  
  - Once you receive the requested information from Linda Hafley, determine if there are any former employees you may want to interview. |
| 10. MOMED (Missouri Medicaid) |                |                | a. Obtain provider information  
  - Determine other provider numbers that target is affiliated with  
  - Determine provider specialties, if applicable  
  - Determine how long provider has been an active Medicaid provider  
  - Determine any changes in provider status (e.g., active, inactive, etc.) |
|                         |                |                | b. Retrieve bank information  
  - Determine who the "pay to" is |
| 11. Secretary of State |                |                | a. Business Entity Information (print and add to case file) |
| Data Analysis |                |                | 12. Analyze Claims Data  
  a. Cross reference your procedure codes with the Medicaid manual, CPT book, CSRs, etc.  
  b. Consult with Chief Investigator, as necessary |
| Investigative Plan |                |                | 13. Create preliminary case summary |
|                     |                |                | 14. Meet with attorneys  
  a. Develop investigative plan (to include time expectations re: future tasks)  
  - E.g., subpoenas, whether time study is necessary/appropriate |
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<th>Task</th>
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<td><strong>Subpoenas Out</strong></td>
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<td><strong>Document Review</strong></td>
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<td><strong>Interviews</strong></td>
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<td><strong>15. Subpoena (Allow 2-4 weeks for return of documents)</strong></td>
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<td>a. Target of the investigation for records</td>
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<td>b. Other: schools, hospitals, employment records, etc.</td>
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<td>o Run Secretary of State business entity information, where applicable</td>
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<td><strong>16. Subpoenaed Documents Arrive</strong></td>
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<td>a. ALL original subpoenaed documents should be given to Linda or Susan as soon as possible, regardless of the method received</td>
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<td>o E.g., includes fax, e-mail attachments, mail, hand delivery</td>
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<td>b. Any other original documents that may hold any evidentiary value (e.g., school records informally faxed to investigator) should be given to Linda or Susan as soon as possible</td>
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<td>c. Linda or Susan scan originals and place originals into evidence locker</td>
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<td>o NOTE: NEVER mark on original subpoenaed evidence.</td>
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<td>d. Linda or Susan Bates stamps the copies of subpoenaed documents and burn documents to a CD for investigator</td>
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<td>o Investigators should track the progress of scanning subpoenaed documents. If the process takes more than 1 week, inform your attorney.</td>
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<td><strong>17. Review subpoenaed documents</strong></td>
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<td><strong>18. Meet with attorneys</strong></td>
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<td>a. Discuss findings in subpoenaed documents</td>
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<td><strong>19. Interviews</strong></td>
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<td>a. Get criminal history information through MULES on all individuals who you plan to interview BEFORE you interview them (where possible). This is important for safety reasons.</td>
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<td>o Do a memo to file to interpret/summarize MULES reports</td>
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<td>b. Interviews</td>
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<td>o NOTE: Remember to always get full identifiers and contact information for each individual you interview</td>
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<td>o Eg., DOB, SSN, home and work addresses, home, work, and/or cell phone numbers, close relative or other acquaintance who would know where individual is</td>
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<td>20. Prepare “Revised Case Summary”</td>
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<td>a. This should include investigative findings and a recommendation to the Director</td>
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<td>21. Once a charging decision has been made – Request Medicaid Data from MHD (with business records affidavit).</td>
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MFCU Prosecutorial Options

1. **Criminal**
   1. Joint Prosecution with County Prosecutors
   2. Direct MFCU Prosecution
   3. Refer for Local Prosecution
   4. Federal Prosecution

2. **Civil**
   1. Direct MFCU Prosecution
   2. Federal Prosecution

3. **Parallel Proceedings**
To obtain jurisdiction in a particular case, the attorney general delivers a **REPORT OF VIOLATIONS** to the appropriate prosecuting attorney.

**Prosecuting attorney can:**
- Commence a prosecution **independently**
- Commence a prosecution **jointly** with the attorney general
- **Decline to file** a case.
  - A written statement must be filed with the attorney general explaining why criminal charges should not be brought.

If the prosecuting attorney takes no action, the attorney general can **proceed independently**.
Deciding How to File

- MFCU looks at various factors in determining whether to file a case civilly, criminally, or to pursue parallel proceedings.

- While determinations are made on a case-by-case basis, MFCU generally looks to:
  1. Quality of care
  2. Egregiousness of behavior (E.g., frequency, loss)
  3. Provider’s previous education / knowledge of acts
Missouri MFCU

- A State Medicaid Fraud Control Unit must be *entirely separate and distinct* from the Medicaid agency. 42 C.F.R. 1007.9

- Missouri’s Medicaid Fraud Control Unit (MFCU) is located within the Public Safety Division of the Attorney General’s Office.
  - **MFCU Team**
    - 6 Attorneys;
    - 9 Investigators;
    - 1 Investigative Auditor;
    - 2 Auditors;
    - 1 Nurse Investigator;
    - 1 Computer Analyst; &
    - 2 Administrative Assistants.
Missouri’s Medicaid Fraud Control Unit prides itself for being efficient, creative, aggressive, and extremely hard-working, keys to our state's success. We pledge to continue doing all we can to uncover money stolen from the Medicaid system and return it to the state's health-care system.

- Attorney General Chris Koster
Medicaid Fraud Prosecution – A Top Priority

"One of my **top priorities** as Attorney General is to enforce our laws against those who cheat Missouri taxpayers by committing Medicaid fraud. We will continue to search for individuals who would perpetrate this kind of fraud, and to recover public money stolen from our health care system."

"Medicaid fraud costs the state of Missouri tens of millions of dollars each year," Koster said. "My office will continue to make discovering, investigating and prosecuting Medicaid fraud one of our **highest priorities**."

"One of my **top priorities** as Attorney General is prosecuting those who cheat Missouri's Medicaid system," Koster said. "This kind of illegal conduct denies medical resources that would otherwise be directed to needy Missourians."
January 2009
- **Cephalon** – pharmaceutical company
  - Off label marketing
  - $1.4M recovery

August 2009
- **Noel Botsch** – Cape Girardeau County pharmacy owner
  - Double billing; submitting false claims
  - $3.9M settlement

September 2009
- **Samuel A. Miller** – Jasper County Dentist
  - Plead[ed GUILTY to 13 counts of Medicaid Fraud
- **Pfizer** – pharmaceutical company
  - $22M recovery re: the drugs Bextra, Geodon, Lyrica, Zyvox, Aricept, Celebrex, Lipitor, Norvasc, Relpax, Viagra, Zithromax, Zoloft and Zyrtec
  - Kickbacks and engaged in off-labeling marketing campaigns

October 2009
- **Mylan Pharmaceuticals, Inc., UDL Laboratories, Inc., AstraZeneca Pharmaceuticals LP, and Ortho McNeil Pharmaceutical, Inc**
  - $2.5M settlement
  - Submitting false claims - improper classification of drugs resulting in paying the state lower rebates
Attorney General Koster’s MFCU Highlights - 2010

- **January 2010**
  - **Cathedral Rock** - Nursing home corporation
    - $90,000 recovery
    - Submitted false cost reports to Medicare and Medicaid for services that were not provided.
    - Substandard care was provided that contributed to serious injury or death of residents
  - **Connie Beckerman** – Perry County bookkeeper
    - AGO CHARGED Beckerman with (financial) abuse of a Medicaid recipient & forgery
- **March 2010**
  - **Roxane, Inc** – pharmaceutical company
    - $3.1 million recovery
    - Reported prices for Medicaid to use as its reimbursement rate that were higher than the amount pharmacies paid for the drug
  - **Miller** – Jasper County Dentist
    - $550,000 recovery
    - Billing for services not provided.
  - **Alpharma Inc.** – pharmaceutical company
    - $840,000 recovery for submitting false claims to Medicaid
Attorney General Koster’s MFCU Highlights - 2010

- **Stephanie Spilton** – St. Louis County counselor
  - Charged with over 300 counts of Medicaid fraud for submitting claims for services never provided
  - Missouri Supreme Court affirms a grant of summary judgement against Spilton for $1.8M
- **Connie Beckerman** – Perry County nursing & rehabilitation center bookkeeper
  - Plead GUILTY to financial abuse of a Medicaid recipient & forgery
- **Kevin W. Louderback** – Greene County insurance broker
  - SENTENCED to 12 years in the Missouri Department of Corrections for misappropriating more than $700,000 from Medicaid.

- **July 2010**
  - **Dana Opfer** – Jasper County Audiologist
    - FILED 3 counts of Medicaid Fraud for billing for services and hearing devices that were not provided

- **August 2010**
  - **Christopher Mayo** – Marion County Nurse’s Aide
    - CHARGED with 1 count of Abuse of a Person Receiving Health Care
September 2010

- **Ortho-McNeil-Janssen Pharmaceuticals, Inc**
  - $1.9 million paid to Missouri as part of a national settlement after the company was accused of engaging in off-label marketing of its anticonvulsant drug Topamax.

- **Teresita Manubay, M.D.** – Dunklin County Pediatrician
  - $200,000 settlement
  - Must hire independent practice auditor & pay 3x the amount of mis-billings.
  - Must hire or train a professional Medicaid coder
  - Must complete provider education training

- **Kos Pharmaceutical**
  - $226,838 awarded to the state and federal government for violations and off-label marketing of its cholesterol treatment drugs Advicor and Niaspan

- **Novartis Pharmaceuticals Corporation**
  - $5.5 million as part of a national settlement for illegal kickbacks and improper sales and marketing practices. The allegations involving various drugs.

October 2010

- **Howard Goldstein** – St. Louis Psychiatrist
  - **CIVIL SETTLEMENT of $176,748.00** for upcoding his Medicaid reimbursement records
Attorney General Koster’s MFCU Highlights – 2010-2011

- **Connie Beckerman** – Perry County bookkeeper
  - Court **SENTENCED** Beckerman for (financial) **abuse of a Medicaid recipient** & forgery, ordering **restitution** & **investigative costs** reaching nearly $20,000.

- **November 2010**
  - **Kimberly Vogelpohl** – CDS provider / recipient
    - Plead guilty to two felony counts of Medicaid fraud and one felony count of forgery
  - **GlaxoSmithKline**
    - $3.5M paid to Missouri resolving allegations that GSK knowingly manufactured, distributed, and sold four drugs whose strength, purity and/or quality fell below the standards required by the FDA

- **December 2010**
  - **Joshua Johnmeyer** – Greene County LPC
    - **AGO FILED** six counts (4 Medicaid Fraud, 1 Obstruction, 1 Stealing).
  - **Elan Pharmaceuticals**
    - $1.7M paid to the state to settle allegations that the company engaged in off-label marketing of its anti-epileptic drug Zonegran

- **January 2011**
  - **Dana Opfer** – Jasper County Audiologist
    - **PLED GUILTY** to three counts of Medicaid Fraud for billing Medicaid for services and devices not provided.

- **February 2011**
  - **Harvest Home Care, LLC** – St. Louis City Personal Care Company
    - Billed Medicaid for Consumer Directed Services when HHC was not licensed to provide CDS services.
    - **Deferred Prosecution Agreement**
      - Pay restitution of $32,707.49
      - Pay penalty of $32,707.49
March 2011

- **Crystal Abernathy** – Pemiscot County, Personal Care Attendant
  - Caused claims to be submitted to Medicaid for personal care services that she did not perform, as she was working elsewhere.
  - **PLED GUILTY** to two felony counts of Medicaid fraud and was sentenced to five years probation & ordered to pay restitution.

- **AstraZeneca Pharmaceuticals LP**
  - $1.5 million paid to the State of Missouri to resolve allegations that AstraZeneca engaged in off-label marketing that improperly promoted the antipsychotic drug, Seroquel, and failed to disclose potentially harmful side effects of Seroquel.

- **Dana Opfer** – Jasper County Audiologist
  - **SENTENCED** to serve five years of supervised probation and ordered to pay more than $30,000 in restitution to the Missouri Medicaid program.

- **Kimberly Vogelpohl** – CDS provider / recipient
  - **SENTENCED** to serve five years of supervised probation, serve 15 days shock time, and pay restitution of over $6,000.

April 2011

- **Kristi M. Smith**, LPC – Pemiscot County
  - **CHARGED** with 4 felony counts of Medicaid fraud, 1 count of Forgery, and 1 count of Stealing by Deceit for billing Medicaid for counseling services she did not provide & falsifying documentation.

- **CMV In-Home Assistance, Inc.** – Personal Care Provider – Pemiscot County
  - **CIVIL SETTLEMENT** with personal care company to repay $375,000 for improper billings while patients in the hospital, or for services provided by attendants unregistered with the FCSR
May 2011
- **Beverly Hills Pharmacy** – St. Louis County
  - **CIVIL SETTLEMENT** with pharmacy to repay $500,000 to resolve allegations that the pharmacy improperly submitted claims to Medicaid after the pharmacy provided a receipt to the recipient to meet their “spend down”
- **Christopher Mayo** – Nurse Aide – Marion County
  - **SENTENCED** to five years in the Department of Corrections for abusing a Medicaid recipient while working as an aide at Levering Regional Health Care Center.

June 2011
- **Lorraine Kusior, LPC** – Counselor, Pulaski County
  - **PLED GUILTY** to two counts of Medicaid Fraud, one count of Obstruction, and one count of Stealing by Deceit for submitting claims to Medicaid for counseling services not provided.
- **Tammy Conaway** – Resident Trust Fund, Crawford County
  - **CHARGED** with nine felony counts for misappropriating funds from nursing home residents while working as a bookkeeper at a nursing home.
- **Smith & Associates** – Personal Care Company, Pemiscot County
  - **CIVIL SETTLEMENT** with personal care company for $74,000 to resolve allegations that the company failed to ensure that personal care services were properly billed to Medicaid.
Attorney General Koster’s MFCU Highlights - 2011

- **July 2011**
  - **Kristi M. Smith, LPC** – Counselor, Pemiscot County
    - **PLED GUILTY** to 1 felony count of Medicaid fraud, 1 count of Forgery, and 1 count of Stealing for submitting claims to Medicaid for counseling services not provided.

- **August 2011**
  - **Thomas Alms, Jr.** – Dentist, Lawrence County
    - **CIVIL FILING** against Alms and his wife for billing Medicaid for services not provided.
  - **Carrie Williams** – Personal Care Aide, St. Louis
    - **CHARGED** with three counts of Medicaid fraud for billing for nurse visits not provided.
  - **Jornel Williams** – Personal Care, St. Louis
    - **CHARGED** with 12 felony counts for submitting claims to Medicaid for nurse visits that were not provided.

- **September 2011**
  - **Maxim Healthcare** – Personal Care, Baltimore, MD
    - **CIVIL SETTLEMENT** of $2.4 million to resolve allegations that Maxim billed Medicaid programs for services not rendered.
Attorney General Koster’s MFCU Highlights - 2011

- **Southwest Center for Independent Living**, Personal Care, Greene County
  - **CIVIL SETTLEMENT** of $43,000 to resolve allegations that SWCIL submitted claims to Medicaid for services not provided by personal care attendant Angela Adams.

- **Kristi M. Smith, LPC** – Counselor, Pemiscot County
  - **SENTENCED** to five years supervised probation and ordered to pay restitution and investigative costs in excess of $15,000.

- October 2011
  - **Pfizer, Inc.** – Pharmaceutical Company
    - Multi-state **CIVIL SETTLEMENT** resolving allegations that Pfizer used off-label marketing to promote a urology drug Detrol. MO received $102,000.
  
  - **MERIL** – Personal Care, Buchanan County
    - **CIVIL SETTLEMENT** for $130,000 resolving allegations that Midland Empire Resources for Independent Living failed to ensure that personal care services were provided to clients.

- **Delmar Gardens**, Personal Care, St. Louis
  - **CIVIL SETTLEMENT** of nearly $580,000 to resolve allegations that Delmar Gardens was reimbursed for in-home health services that were not eligible for reimbursement (e.g., ineligible relationship or when services were not provided).
November 2011

- **Joshua Johnmeyer**, LPC – Counselor, Greene County
  - **SENTENCED** to serve five years probation with seven days of shock incarceration in the county jail. Johnmeyer paid $3,684 in restitution.

- **Abdullah Jamaal M. Ali, LCSW** – Counselor, St. Charles County
  - **CHARGED** with nine felony counts of Medicaid fraud for submitting false reimbursement claims to Medicaid for counseling services he did not perform.

- **Merck** - Pharmaceutical Company
  - **SETTLED** civil and criminal allegations that Merck marketed its drug Vioxx for uses not approved by the FDA, misrepresented the cardiovascular safety issues relating to the drug and otherwise made false and misleading representations about Vioxx. MO received over $13 Million.

December 2011

- **Angela D. Adams**, PCA, Greene County
  - **CHARGED** with six counts of Medicaid fraud for causing claims to be submitted to Medicaid for in-home services that she did not provide, as she was working elsewhere or the recipient was in the hospital.

- **Lana Reece-Gates**, PCA/Owner, St. Louis
  - **DEFERRED PROSECUTION AGREEMENT** reached wherein Reece-Gates will pay $15,000 for submitting false claims to Medicaid and failed to run appropriate background screenings on personal care attendants.
January 2012

- **Carolyn Koenig & 3 PCAs**, Texas County
  - CHARGED with various counts of Medicaid fraud and stealing for causing nearly $13,000 in false claims to be submitted to Medicaid from 2009 to 2011 for personal care services that were not actually provided.

- **Betty J. Bertholet**, Stoddard County
  - DEFERRED PROSECUTION AGREEMENT wherein Bertholet admitted to billing for counseling services she did not provide and supplying MFCU with falsified records. Bertholet paid the state $27,190 in restitution and forfeited her Medicaid-provider status.

February 2012

- **Tammy F. Conaway**, Bookkeeper, Crawford County
  - SENTENCED to 120 days shock incarceration in the Department of Corrections for stealing funds from nursing home residents where she was the bookkeeper.

- **KV Pharmaceutical**, Pharmaceutical Company
  - SETTLED allegations that KV Pharmaceutical misrepresented that two drugs were approved for coverage under federal and state health care programs, including Medicaid. MO will receive $289,000.
Attorney General Koster’s MFCU Highlights - 2012

- **March 2012**
  - **Pamela S. Smith**, Bookkeeper, Scott County
    - **CHARGED** with misappropriating thousands of dollars from nursing home residents while she worked as the bookkeeper at a nursing home.

- **April 2012**
  - **Just What the Doctor Ordered, Inc.**, DME Provider, Howard County
    - **DEFERRED PROSECUTION AGREEMENT** wherein Teresa Linneman, owner/operator of JWTDO, admitted criminal liability for billing Medicaid for more than 27,000 diapers that were never provided to Medicaid recipients and paid the state over $217,000 in restitution, damages, penalties, and costs.

- **June 2012**
  - **Abdullah Jamaal M. Ali**, St. Charles County
    - **PLED GUILTY** to 3 counts of Medicaid Fraud for submitting false claims for counseling services not provided. Ali was sentenced to 5 years in prison and ordered to pay restitution and damages in the amount of $25,230. Ali was also permanently barred from the Medicaid program.
  - **Reliable Home Health Services**, St. Louis County
    - **SETTLED**. Allegations that Reliable billed Medicaid for personal care services not provided. Restitution and penalties of $124,164.
July 2012
- **Pamela Sue Smith**, Scott County
  - PLED GUILTY to 2 felony stealing counts and was sentenced to 5 years in prison on each count, execution of the sentence was suspended. Smith was a Bookkeeper for a nursing home who stole from patient trust accounts. Smith was also ordered to repay $37,134.78 in restitution.

September 2012
- **Carol Koenig, Alethea Stemick, Casie Koenig and Melinda Alterauge**, Texas County
  - PLED GUILTY. All 4 pled guilty to Medicaid fraud, 2 of pled guilty to class C felony stealing. Medicaid recipient in the consumer directed services program, along with 3 of her attendants, involved in a scheme to commit fraud by submitting false timesheets.
Comfort Dental, Jackson County

SETTLED A franchise dental chain based in Colorado with offices in the Kansas City area – billed Medicaid for services provided to individuals who were not eligible for Medicaid, resulting in a total loss to Medicaid of more than $17,000. Additionally, the Attorney General’s investigation revealed that each clinic double-billed services to Medicaid, resulting in a loss of more than $4,200, and also charged Medicaid recipients for services paid for by the program.

In three separate settlements, the entities paid $66,265.22 to resolve claims of both the Medicaid Fraud Control Unit and the Consumer Protection Division. The Consumer Protection Division sent checks totaling $6,265.22 to those Missouri citizens who were improperly billed for Medicaid covered services.

January 2013

Dr. Arrash Ahmadnia, Ozark Family Dentistry, Camden County

SETTLED allegations that he billed Medicaid for dental fillings but actually performed the less expensive treatment of preventative resin restorations. Under the settlement, Dr. Ahmadnia is required to pay more than $208,000. This case originated from a whistleblower and resulted in a award to the whistleblower in the amount of $8,239.
February 2013

- **Infiniti Home Health, Inc.**, St. Louis County
  - SETTLED allegations that Infiniti billed for home health care services to elderly and disabled Missourians that were not provided. Under the agreement, Infiniti must pay $174,504 in restitution, penalties and damages.

- **Kono Care Services, LLC**, Jackson County
  - SETTLED allegations that Kono billed for home health services that could not have been provided because its clients were hospitalized at the time the services were claimed to have been provided. Under the agreement, Kono is to pay $23,108 in damages, penalties and investigative costs.

March 2013

- **Adult Daycare Villas, LLC**, Jackson County
  - SETTLED allegations that Adult Daycare Villas billed Medicaid for full day services to its clients when in fact half day services were provided. Under the agreement, Adult Day Care Villas must pay $67,725.64 in restitution, damages, penalties and investigative costs.
Angel’s Care, Inc., St. Louis County

SETTLED allegations that billed Medicaid for at home personal care services to clients that were client’s hospitalized and for two clients that were deceased. Under the agreement, Angel’s Care, Inc. must pay $149,000 comprised of restitution, penalties, damages, and investigative costs.
Missouri MFCU
National Rankings:

2009
- 1st Place – Dollar Recovery per Conviction, Judgment, or Settlement
- 2nd Place – Dollar Recovery per MFCU staff
- 2nd Place – Dollar Recovery per Grant Dollar

2010
- 1st Place – Dollar Recovery per Conviction, Judgment, or Settlement
- 1st Place – Dollar Recovery per MFCU staff
- 1st Place – Dollar Recovery per Grant Dollar

2011
- 5th Place – Dollar Recovery per Conviction, Judgment, or Settlement
- 3rd Place – Dollar Recovery per MFCU staff
- 3rd Place – Dollar Recovery per Grant Dollar
Missouri Attorney General’s Investigative Authority

- **General Investigative Power:**
  - “The attorney general shall have authority to investigate alleged or suspected violations of sections 191.900 to 191.910.” - §191.910.1, RSMo.

- **Subpoena Power:**
  - “In any investigation, hearing or other proceeding pursuant to sections 191.900 to 191.910, any record in the possession or control of a health care provider...shall be made available by the health care provider to the attorney general...”
Missouri Medicaid Fraud Statute

- **Section 191.905, RSMo**
  - “No health care provider shall knowingly make or cause to be made a false statement or false representation of a material fact in order to receive a health care payment.”

- **Elements** (*State v. Barnes*)
  1. Defendant made or caused to be made a representation;
  2. Representation was made for the purpose of receiving a health care payment;
  3. Representation was false;
  4. Representation was material;
  5. Defendant was a health care provider;
  6. Defendant acted knowingly.
Element #1:

Defendant made or caused to be made a representation

- Claims were submitted to Medicaid either by:
  1. The provider directly, or
  2. A person operating at the direction of the provider:
    - Employee of provider
    - Person with contractual relationship to provider
Element #2: Representation was made in order to receive a health care payment

- Provider was enrolled in the Medicaid system and, as an enrolled provider, was entitled to payments for services he/she provided
- Based upon the submitted claims, funds were transferred to Provider.
Element #3:

Representation was false

- “False” - wholly or partially untrue.
  - A false statement or false representation of a material fact means the failure to reveal material facts in a manner which is intended to deceive a health care payer with respect to a claim.

- E.g., The product(s) and/or service(s) were not provided as asserted on the claim(s).
Element #4:

**Representation was material**

- Medicaid relied upon the statement to determine whether to pay the claim or how much to pay for the claim.
- E.g., for some claims, a specific place of service may result in a greater reimbursement than other places of service.
Element #5:

Defendant was a health care provider

- Any person delivering, or purporting to deliver, any health care;
- Any employee, agent or other representative of such a person;
- Any employee, representative, or subcontractor of the state of Missouri delivering, purporting to deliver, or arranging for the delivery of any health care.
Element #6: Defendant acted knowingly.

- Actual knowledge of information; or
- Deliberate ignorance of the truth or falsity of the information; or
- Reckless disregard of the truth or falsity of the information.
- Use of the terms knowing or knowingly shall be construed to include the term "intentionally", which means that a person, with respect to information, intended to act in violation of the law.
COUNT I:

That the defendant, in violation of Section 191.905.1 RSMo, committed the class C felony of Medicaid Fraud: making a false statement to receive a health care payment, punishable upon conviction under Sections 558.011 and 560.011 RSMo in that on or about July 8, 2008, partly in one county and partly in one or more other counties, an element of which occurred in the County of Wright, State of Missouri, the defendant was a health care provider and knowingly caused a false representation to be made to the Missouri Department of Social Services, a health care payer, for the purpose of receiving a health care payment, that defendant provided one hour of psychiatric diagnostic interview examination service to C. M., an eligible Medicaid recipient, on June 20, 2008, which was a false representation of material fact and known by the defendant to be false when made.
What is a claim?

**Statutory Definitions:**
- A “claim” is *any attempt* to cause a health care payer to make a health care payment.
- A “claim” is “false” if it is *wholly* or *partially* untrue.

**Practically Speaking:**
- A “claim” is typically an ICN. Every time that a provider “hits enter” – it’s a new claim for payment.
- If an ICN has 10 lines and only one line is false, the entire ICN may be deemed to be false.
Medicaid Fraud Penalties

CRIMINAL

- **Imprisonment**
  - Medicaid Fraud is a Class C felony
  - Penalty of imprisonment of up to seven (7) years.

- **Civil Monetary Penalties**
  - Not less than $5,000 to $10,000 per false claim
  - Treble damages
  - Restitution

- “Beyond a Reasonable Doubt”
Medicaid Fraud Penalties
CIVIL

- **If “Knowing” Violation**
  - Not less than $5,000 to $10,000 per false claim
  - Treble damages
  - Restitution

- **If “Unintentional” Violation**
  - Double Damages

- “Preponderance of the Evidence”

See *State v. Spilton*, 315 S.W.3d 350 (Mo. 2010).
Medicaid Fraud Case Progression

False Claim

Intentional (Civil or Criminal)

Unintentional (Civil)
  - Restitution
  - Double Damages
  - Investigative Costs

Beyond a Reasonable Doubt

CRIMINAL
  - Restitution
  - Treble Damages
  - $5,000 to $10,000 per
  - Investigative Costs
  - Prison

Preponderance of the Evidence

CIVIL
  - Restitution
  - Treble Damages
  - $5,000 to $10,000 per
  - Investigative Costs
Obstruction of a Medicaid Fraud Investigation

- §191.905.8, RSMo. Any natural person who willfully prevents, obstructs, misleads, delays, or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of sections 191.900 to 191.910 is guilty of a class D felony.

- Providers are most commonly prosecuted for obstruction for altering patient records.
Facts

- Licensed Clinical Social Worker (LCSW) in St. Louis County

- During 2004, over 77% of Spilton’s claims submitted to Medicaid were false.

- Billing for services not provided.
  - Fabricating detailed progress notes for sessions with clients that never occurred;
  - Billing while children were in school;
  - Billing for “in home” services when child no longer lived at the residence indicated.
The State’s Arguments

**Factual Argument:**
- Spilton “knowingly” violated §191.905.1, RSMo.
  - Oral and written confessions
  - Impossibility that services were provided on many dates
  - Adverse inference from assertion of 5th Amendment privilege

**Statutory Argument:**
- The determination regarding which subsection to prosecute under is not contingent upon the nature of the charge (e.g. civil or criminal), but instead hinges upon whether Spilton acted “knowingly.”
  - Section 191.905.12, RSMo, allows civil penalties and treble damages for knowing violations in civil or criminal cases.
  - Section 191.905.14, RSMo, allows double damages for unintentional violations in civil cases.
- Because Spilton acted knowingly, §191.905.12, RSMo, was the appropriate statutory provision to use.

**Constitutional Arguments:**
- Section 191.905.12, RSMo, is neither unconstitutionally excessive nor vague.
State v. Spilton
315 S.W.3d 350 (Mo. banc 2010).

**Spilton’s Arguments**

- **Factual Argument:**
  - The State did not prove that Spilton “knowingly” violated §191.905.1, RSMo.

- **Statutory Argument:**
  - The State is not entitled to civil penalties under §191.905.12, RSMo.
  - The language in §191.905.14, RSMo, ("the attorney general may bring a civil action") requires that §191.905.14, RSMo, supply the exclusive remedy in civil claims.

- **Constitutional Arguments:**
  - Section 191.905.12, RSMo, is **unconstitutionally excessive**.
  - Section 191.905.12, RSMo, is **unconstitutionally vague** and subject to inconsistent application.
Section 191.905, RSMo

Subsection 1
- No health care provider shall knowingly make or cause to be made a false statement or false representation of a material fact in order to receive a health care payment.

Subsection 12
- A person who violates subsections 1 to 3 of this section shall be liable for:
  - A civil penalty of not less than $5,000 and not more than $10,000 for each separate act in violation of such subsections
  - Plus three times the amount of damages which the state and federal government sustained because of the act of that person.

Subsection 14
- The attorney general may bring a civil action against any person who shall receive a health care payment as a result of a false statement or false representation of a material fact made or caused to be made by that person.
- The person shall be liable for up to double the amount of all payments received by that person based upon the false statement or false representation of a material fact, and the reasonable costs attributable to the prosecution of the civil action.
Penalties

- Actual Damages $45,385.00
- Treble Damages $136,155.00
- Civil Penalty** $1,625,000.00

$1,806,540.00

**Civil Penalty assessed at $5,000 for each of the 325 false claims
Implications of State v. Spilton

- Confirms state’s ability to seek civil monetary penalties in criminal OR civil Medicaid Fraud cases.

  - Confirms state’s ability to seek treble damages and civil monetary penalties for civil or criminal cases of “knowing” violations.

  - Confirms state’s ability to seek double damages in civil cases of “unknowing” or “unintentional” violations.
## Common Charges

<table>
<thead>
<tr>
<th>CRIMINAL</th>
<th>CIVIL</th>
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<tr>
<td>Medicaid Fraud</td>
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<tr>
<td>Forgery</td>
<td>Breach of Contract</td>
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<tr>
<td>Stealing by Deceit</td>
<td>Unjust Enrichment</td>
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<tr>
<td>Abuse of a person receiving health care</td>
<td>Fraudulent Misrepresentation</td>
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<td></td>
<td>Consumer Fraud</td>
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Ancillary Penalties for violations of §191.900 – §191.910, RSMo.

- **Discipline** from licensing board
- **Loss** of professional license
- Placement on the Employee Disqualification List (EDL)
- **Suspension** from Medicaid
- **Exclusion** from Medicaid and other federal programs
Restorative Justice

- **Restorative justice** is a way of seeing crime as more than breaking the law – it also causes harm to people, relationships, and the community.

  - All parties with a stake in a particular offense come together to **collectively resolve** how to deal with the aftermath of the offense and its implications for the future.

- In appropriate instances, MFCU may settle cases in such a way to allow providers to **avoid prosecution** as long as they **remedy** their inappropriate behavior.
  - Deferred prosecutions
  - Self-audits
  - Professional billing/coding education
  - Pre-payment review
Managing Risk of Fraud Prosecution

- **Bill accurately** – use appropriate codes
- **Keep thorough/complete records** – make sure they are up to Medicaid standards.
- **Keep a good staff** – Hire well-qualified billing specialists and keep them well trained
- **Stay informed** –
  - Stay up-to-date on Medicaid **provider manuals**
  - Take advantage of **provider education** provided by DSS
  - **Communicate** – Contact the Provider Education Unit of the DSS with questions
- The majority of MFCU cases relate to providers **billing for services not rendered** or **upcoding**.
Common FFS Fraud Schemes

1. **Billing for medical services not actually provided**

2. **Upcoding**
   - Billing for a more expensive service than was actually rendered

3. **Unbundling**
   - Billing for several services that should be combined into one billing

4. **Billing twice for the same medical service**
   - E.g., billing for pulling the same tooth twice

5. **Dispensing generic drugs and billing for brand-name drugs**
Common Fraud Schemes

- Home health/personal care home based services claimed while participant is hospitalized or in a nursing home.
- Home health/personal care home based services claimed while employee is working for another employer.
- Adult Day Care services claimed on the weekends and holidays when facility is only open M-F.
- Claims for dates of service after death.
- Physicians billing multiple new patient visits.
- Dentist billing for multiple extractions of the same tooth.
- Dentist billing for each part of dentures (impressions, dentures, and fillings).
Analyzing Claims Data by Provider Type

- **Adult Day Care**
  - Billing for services not provided
  - Billing for daycare when recipient is in the hospital or nursing home
  - Overlapping claims with other service providers
  - Daycare is a storefront, not really a daycare facility

- **DME/Audiology**
  - Billing for services, devices and/or dispensing fees when not provided
  - Billing for power wheelchair but providing a manual wheelchair
  - Company is a storefront
Analyzing Claims Data by Provider Type

- **Counselor/Therapist/Licensed Clinical Social Workers**
- Billing multiple family sessions for the same family on the same day
- Billing for many families that live large distances from each other on the same day (allowing inadequate travel time)
- Recipient seeing other counseling providers on the same day
- Billing for seeing recipient in their home when services were provided in the office resulting in higher reimbursement
- Billing when recipient was obviously not available for appointment (hospitalized, moved away)
- A pattern of overlapping appointments in which all or a large portion of the individual sessions occurred at the same time (small portions of sessions that overlap are not necessarily indicative of fraud)
- Consistently billing for more than 15 hours per day
- Continuing to bill for services after therapy has concluded
- Providing service for one child but billing for individual sessions for every child in the family
Analyzing Claims Data by Provider Type

- **Pharmacy**
  - Billing for prescriptions not dispensed
  - Billing for brand name medications when generics are dispensed
  - Billing for commercially prepared substances where pharmacist dispensed compounded medications
- **Dentists**
  - Billing the same procedure repeatedly on the same tooth
  - A pattern of multiple extractions of the same tooth
  - A pattern of unbundling restorations or services (e.g. billing a three sided and a one sided restorations instead of a four sided restoration)
  - Billing a large number of procedures that are not generally age appropriate (e.g. root canals for children under 9, a pattern of a large number of pulpotomies – more than 12-on children)
  - A pattern of billing for large numbers of crowns for children
  - A pattern of billing for adults who are ineligible for dental coverage
  - Upcoding (e.g. billing for deep sedation when only using N₂O)
  - Billing for x-rays when none are in the patient file
Analyzing Claims Data by Provider Type

- **Physicians/Nurse Practitioners**
  - A pattern of billing an excessive number of hours per day
  - Upcoding E&M codes (e.g. billing 99214 for all visits when only spending five minutes with the recipient)
  - Treating one member of a family but billing for services for each member of the family
  - Billing for telephone or office contacts with non-licensed office staff
  - A pattern of requiring recipients to come to the office more than two times per month to obtain prescriptions without a valid medical reason
  - Billing for services not provided
  - Billing for services provided by an excluded provider by using another provider’s provider number

- **Long Term Care Practitioners**
  - A pattern of billing for recipients who are not in the facility (e.g. nursing home recipients who are hospitalized)
  - “Hallway Walking” or billing for every resident in the facility when the provider only saw a few residents
Analyzing Claims Data by Provider Type

- **Home Health/Personal Care/Homemaker Chore**
  - Consumer and Attendant sign timesheets claiming work was done when it was not (Often they split the payment for the claimed service)
  - Attendant works for more than one company with the result of an excessive number of hours of services provided (e.g. working for five different companies and billing for more than 24 hours in a day)
  - Situations in which the service could not have occurred because the Consumer or Attendant were unable to have received/provided the service (e.g. Consumer/Attendant was hospitalized, on vacation, at another job or incarcerated)
  - Attendant is disqualified from being able to provide services (Family Care Safety Registry issue)

- **Podiatrists**
  - A pattern of billing for nail avulsions or other complicated procedures when routine nail care is actually being performed
  - Billing for treatment for recipients who have had amputations rendering the service impossible
National Association of Medicaid Fraud Control Units (NAMFCU)
National Association of Medicaid Fraud Control Units (NAMFCU)

- Founded in 1978 to:
  - Share information on a nationwide basis;
  - Provide training for state MFCUs; &
  - Represent MFCUs with Congress & HHS/OIG.

- Headquarters in Washington D.C. at the National Association of Attorneys General (NAAG)
NAMFCU Global Cases

- DOJ has authority to settle Medicare and federally funded portion of Medicaid claims.
  - **DOJ does NOT have authority to settle the state portion of Medicaid claims.**

- Global Cases Involve:
  - National or Multi-State Defendants
  - Global resolution of state & federal issues.

- Since 1992, NAMFCU has settled more than 60 cases and returned more than **$5 billion** to state Medicaid programs.

- During past 4 years, NAMFCU global process produced recoveries in **20 pharmaceutical cases**.
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