

Part III:

**Legal and Investigative Activities
Related to Medicare and Medicaid**

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NOTE: Summaries of OIG audit and evaluation reports in this publication contain rounded figures. Monetary amounts in case narratives are rounded to the next lower dollar, where appropriate.

Part III:

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Investigative Outcomes

During this semiannual reporting period, the Government's enforcement efforts resulted in 294 criminal actions and 196 civil actions against individuals or entities that engaged in health-care-related offenses. These efforts resulted in \$2.6 billion in Department of Health and Human Services (HHS) and \$618 million in non-HHS investigative receivables, including civil and administrative settlements or civil judgments related to Medicare; Medicaid; and other Federal, State, and private health care programs.

Advisory Opinions and Other Guidance

As part of the Office of Inspector General's (OIG) continuing efforts to promote the highest level of ethical and lawful conduct by the health care industry, we issue advisory opinions and other guidance to educate industry and other stakeholders on how to avoid fraud, waste, and abuse.

In accordance with section 205 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), OIG, in consultation with the Department of Justice (DOJ), issues advisory opinions to outside parties regarding the interpretation and applicability of certain statutes relating to Federal health care programs. This authority allows OIG to provide case-specific formal guidance on the application of the anti-kickback statute and safe harbor provisions and other OIG health care fraud and abuse sanctions. From October 1, 2010, through March 31, 2011, OIG received 22 advisory opinion requests and issued 7 advisory opinions. [Advisory opinions](#) are available on our Web site.

OIG also publishes on its Web site [compliance program guidance](#), [fraud alerts](#), [special advisory bulletins](#), and [other guidance](#). On October 20, 2010, OIG published [guidance](#) that sets forth nonbinding factors OIG will consider in deciding whether to impose permissive exclusion in accordance with the Social Security Act, § 1128(b)(15)(A)(ii), which authorizes us to exclude an officer or managing employee of an entity that has been excluded from Federal health care programs or has been convicted of certain offenses.

Education and Outreach Activities

■ Roadmap for New Physicians

A recent OIG review indicated that almost half of medical schools and more than two-thirds of institutions offering residency and fellowship programs reported instructing participants about compliance with Medicare and Medicaid fraud and abuse laws. Because nearly all were interested in having OIG provide instructional materials, we developed a guide called *A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse* (Roadmap). The package also includes a slide presentation and speaker notes.

The Roadmap summarizes the five main Federal fraud and abuse laws (the False Claims Act (FCA), the anti-kickback statute, the physician self-referral law (Stark Law), OIG's exclusion authorities, and civil monetary penalties authorities). It instructs physicians how to uphold these laws in their relationships with payers such as the Medicare and Medicaid programs; vendors such as drug, biologic, and medical device companies; and other providers such as hospitals, nursing homes, and physician colleagues. You can view the [survey](#) and [Roadmap](#) on our Web site at <http://www.oig.hhs.gov>.

■ Provider Compliance Training Sessions

Our Provider Compliance Training initiative provides free, high-quality compliance training sessions for medical providers and suppliers, compliance professionals, and attorneys in various locations throughout the country. Representatives from OIG, DOJ, HHS's Centers for Medicare & Medicaid Services (CMS), and State Medicaid Fraud Control Units (MFCU) educate communities about fraud risks and share compliance best practices to assist providers in strengthening their compliance efforts. The training helps providers to:

- understand laws and compliance program basics;
- know where to go when a compliance issue arises; and
- understand the consequences of health care fraud and abuse.

During the reporting period, we conducted sessions in Houston, Kansas City, and Tampa and have sessions planned in three other cities. Because all sessions filled quickly, we scheduled a Webcast of our Washington, DC, training in May 2011.

■ Most-Wanted Fugitives List

For the first time, we published a [Most-Wanted Fugitives](#) list on our Web site, and captures were soon reported. The 10 individuals on the original list allegedly defrauded taxpayers of more than \$126.6 million. As of March 31, 2011, four had been captured and more were added.

HEAT: Health Care Fraud Prevention & Enforcement Action Team

In 2009, HHS and DOJ announced the Health Care Fraud Prevention and Enforcement Action Team (HEAT), whose mission is to prevent, deter, and aggressively prosecute health care fraud, waste, and abuse. OIG's participation in Medicare Fraud Strike Force activities is a key example of OIG's contribution to the mission of HEAT.

■ Medicare Fraud Strike Force

The Medicare Fraud Strike Force is a partnership between DOJ, U.S. Attorneys' Offices, OIG, the Federal Bureau of Investigation (FBI), and State and local law enforcement agencies. The Strike Force, a key component of HEAT, has a proven record of successfully analyzing data to quickly identify and prosecute fraud almost as quickly as it occurs. The Strike Force began in March 2007 and is now operating in nine major cities: Miami, Florida; Los Angeles, California; Detroit, Michigan; Houston, Texas; Brooklyn, New York; Baton Rouge, Louisiana; Tampa, Florida; Chicago, Illinois; and Dallas, Texas. During this semiannual reporting period, Strike Force efforts have resulted in the filing of charges against 213 individuals or entities, 107 convictions, and \$63.9 million in investigative receivables.

In February 2011, Strike Force teams engaged in an unprecedented Federal health care fraud takedown. Teams across the country arrested more than 100 defendants in 9 cities, including doctors, nurses, health care company owners and executives, and others, for their alleged participation in Medicare fraud schemes involving more than \$225 million in false billing. The defendants are accused of various health-care-related crimes ranging from violating the anti-kickback statute to money laundering to aggravated identity theft. More than 300 special agents from OIG participated in partnership with other Federal and State agencies, including fellow OIGs. The effectiveness of the Strike Force model is enhanced by interagency collaboration. For example, we refer credible allegations of fraud to CMS so it can suspend payments to the perpetrators of these schemes. During the February Strike Force operations, OIG and CMS worked to impose payment suspensions that immediately prevented a loss of more than a quarter-million dollars in claims submitted by Strike Force targets.

Examples of Strike Force cases follow.

- **Florida**—Yudel Cayro, owner and operator of Courtesy Medical Group Inc. (CMG), a medical clinic in Miami, was sentenced to 60 months of incarceration and ordered to pay \$9.8 million for his role in a Medicare fraud scheme. Another owner and operator of CMG, co-defendant Arturo Fonseca, was sentenced to 60 months of incarceration. CMG allegedly provided unnecessary prescriptions, plans of care and medical certifications to Miami-area home health agencies in return for kickbacks and bribes. CMG falsified patient files to make it appear as if Medicare beneficiaries qualified for daily skilled nursing visits to administer diabetic insulin injections. In fact, the beneficiaries did not need or qualify for

these services and in some cases, did not receive the services. CMG issued approximately 344 unnecessary prescriptions.

- **Michigan**—Christopher Collins, a licensed Registered Nurse, was sentenced to 63 months of incarceration and ordered to pay \$6.6 million jointly and severally in restitution with other defendants for health care fraud conspiracy. Collins, a co-owner of All American Home Care (All American), conspired with the owner, and several other co-conspirators to pay kickbacks to Medicare beneficiaries, who, in turn, served as purported patients at All American and Patient Choice Home Health Care. These Medicare beneficiaries received cash and other methods of payment in exchange for signing documents making it appear that they had received the treatments being billed to Medicare when, in fact, the treatments were medically unnecessary or were not provided.
- **Florida**—Flor Crisologo, owner and operator of J & F Community Medical Center Inc. (J & F), was sentenced to 120 months of incarceration and ordered to pay \$8 million in restitution for conspiracy to commit health care fraud. Crisologo, in collaboration with a physician and other individuals, allegedly utilized J & F to submit false and fraudulent claims to Medicare for human immunodeficiency virus (HIV) injection and infusion services. Crisologo and her conspirators paid Medicare beneficiaries kickbacks to induce them to claim that they received legitimate services at J & F when, in fact, the HIV infusion services were not provided or were not medically necessary.

Other Criminal and Civil Enforcement Activities

One of the most common types of fraud perpetrated against Medicare, Medicaid, and other Federal health care programs involves filing false claims for reimbursement. False claims may be pursued under Federal and State criminal statutes and, in appropriate cases, under the FCA. A description of these enforcement authorities can be found in Appendix D.

The successful resolution of false claims often involves the combined investigative efforts and resources of OIG, FBI, MFCUs, and other law enforcement agencies.

DOJ and OIG launched a program in which OIG attorneys serve as Special Assistant United States Attorneys. OIG attorneys are detailed full time to DOJ's Criminal Division, Fraud Section, for temporary assignments, such as with the Medicare Fraud Strike Force described above; others prosecute matters on a case-by-case basis. Both arrangements offer excellent litigation training for OIG attorneys and enhance collaboration between the departments in fighting fraud. Under this program, OIG attorneys have successfully litigated important criminal cases relating to durable medical equipment (DME), infusion therapy, physical therapy, and other types of Medicare and Medicaid fraud.

■ Pharmaceutical Manufacturers and Pharmacies

- **Massachusetts**—As part of a global resolution of allegations under the FCA, GlaxoSmithKline LLC (GSK) agreed to pay \$750 million, including criminal fines for violations of the Federal Food, Drug, and Cosmetic Act (FDCA). The Government alleged that between January 1, 2001, and April 1, 2005, GSK, via its now closed subsidiary SB Pharmco, manufactured, distributed, and sold defective and contaminated drugs. The drugs consisted of (1) Paxil CR that contained some split tablets causing consumers to receive either product with no active ingredient and/or with only the active ingredient layer and no controlled release mechanism; (2) Avandamet that contained some tablets with higher or lower amounts of rosiglitazone than specified; (3) Kytril that was labeled as sterile but was, in some vials, nonsterile; and (4) Bactroban ointments and creams that, in some packages, contained microorganisms. The Government contends that this improper conduct resulted in the submission of false claims to the Federal health care programs. As a result of this investigation, SB Pharmco agreed to plead to a felony violation of the FDCA for violating current good manufacturing practice requirements and introducing adulterated drugs into interstate commerce.
- **Georgia**—Allergan, Inc. and Allergan USA, Inc. (collectively, Allergan) agreed to pay \$600 million and enter a global criminal, civil, and administrative settlement in connection with the improper marketing and promotion of Botox. Under the civil settlement agreement, Allergan agreed to pay the Federal Government \$225 million to resolve its FCA. Botox is a neurotoxin and a biologic that was approved by the Food and Drug Administration (FDA) for several uses, including blepharospasm (uncontrollable closing of the eyelids); cervical dystonia (muscle spasm and pain in the neck and shoulder); and temporary improvement in the appearance of moderate to severe glabellar lines (facial age wrinkles) in adults up to age 65. The settlement resolves allegations that Allergan promoted the sale and use of Botox for a variety of conditions, such as headache, pain, spasticity, and overactive bladder, which were not approved by the FDA and were not covered by the State Medicaid programs.

The settlement further resolves allegations that Allergan: (1) misled physicians about the safety and efficacy of unapproved uses of Botox; (2) instructed health care professionals to miscode claims for the treatment of headache and pain using inapplicable diagnosis codes to ensure payment by various Federal health care programs; and (3) offered and paid illegal remuneration to health care professionals that was intended to induce them to promote and prescribe Botox. As part of the settlement, Allergan entered into a comprehensive 5-year corporate integrity agreement with OIG, which included several provisions intended to increase transparency about Allergan's promotional practices, and which required Allergan to establish internal monitoring programs to review promotional activities.

- **Wisconsin & Louisiana**—Kos Pharmaceuticals (Kos) entered into an approximately \$41 million global criminal, civil, and administrative settlement agreement. Under the civil settlement agreement, Kos agreed to pay the Federal Government \$38.1 million to resolve FCA allegations in connection with improper marketing and promotion practices associated with the drugs Niaspan and Advicor. The Government contends that Kos intentionally marketed Advicor for therapy that did not comport with the uses indicated in its label during the relevant time period. Kos also agreed to enter into a Deferred Prosecution Agreement to resolve criminal liability in connection with the company's violation of the anti-kickback statute. Kos allegedly paid substantial inducements to encourage physicians to prescribe Advicor and Niaspan to patients. The payments took several forms, including honoraria for false speaker programs, grants for sham studies, and payments for participating in phony preceptorship programs. In addition, the company paid managed care organizations who directed their affiliate physicians to switch patients to Advicor and Niaspan.
- **New Jersey**—CVS Pharmacy, LLC agreed to pay \$969,230 to resolve its liability under the FCA. From September 20, 2005, through July 31, 2009, three CVS Pharmacy stores, two in New York and one in New Jersey, allegedly submitted or caused to be submitted to the TRICARE and Medicare programs claims for prescription drugs that were dispensed by an excluded pharmacist. The pharmacist filled the prescriptions and entered data into a system that was then used to bill Medicare. The pharmacist was excluded in 2004 from participating in Federal health care programs based on his conviction for attempted criminal sale of a controlled substance in New York.

■ Hospitals

- **Indiana**—St. John's Health System (St. John's) agreed to pay the United States \$318,364 to resolve its liability under the FCA for submitting fraudulent claims to Medicare and Medicaid for psychotherapy services. The settlement resolves allegations that, from January 1, 2005 through December 31, 2008, St. John's billed for multiple units of psychotherapy services under the code for group medical psychotherapy. The Government contends that the services that were provided, however, were not psychotherapy sessions, but group counseling meetings, including Alcoholics Anonymous meetings provided by unqualified professionals. The settlement also resolved allegations that St. John's billed for services provided by lower-level practitioners without using modifiers to indicate who provided the services, resulting in a 25% higher payment under Medicare and Medicaid.
- **California**—Christus Health and seven of its hospitals (collectively, Christus) agreed to pay \$970,987 to resolve their civil liability for allegedly violating the FCA, the civil monetary penalties law, and certain common law causes of action.

Christus is a health system that operates hospitals throughout the southwestern United States. At the advice of a consulting firm, Healthcare Financial Advisers (HFA), Christus allegedly filed inflated cost reports. HFA allegedly prepared and Christus filed cost reports that sought reimbursement for various categories of items of unallowable costs, while simultaneously preparing a second set of cost reports, which more accurately represented the amount of reimbursement to which the hospitals were entitled. In addition to the settlement amount, Christus also refunded to Medicare a \$649,210 overpayment which it received as a result of improperly seeking reimbursement for unallowable costs on past cost reports.

■ Durable Medical Equipment Suppliers

- **Texas**—Dr. Howard Grant, Obisike Nwankwo, John Lachman, Michael Obasi, Basil Kalu, and Darnell Willis were sentenced to 41 months, 21 months, 26 months, 46 months, 70 months, and 41 months of incarceration, respectively, for their roles in a DME fraud scheme at Onward Medical Supplies (Onward). Two others, Ju Qian and Clinton Lee Jr., were sentenced to 10 months of community and home confinement and 3 years of probation, respectively. Restitution was ordered jointly and severally among the defendants in excess of \$1.3 million. Evidence presented at trial showed that from 2003 to 2009, Onward billed Medicare for fraudulent DME, including power wheelchairs and orthotic devices. Under the scheme, Grant ratified prescriptions for medically unnecessary DME, Lachman created fraudulent patient files and paid kickbacks to recruiters, and Nwankwo delivered DME, such as power wheelchairs and orthotics, to beneficiaries who had no medical need for the equipment. The owner of Onward, Doris Vinitzki, and other remaining defendants have pleaded guilty for their participation in various parts of the fraud scheme. Judicial proceedings continue for those individuals. This Medicare Fraud Strike Force investigation was a joint investigation between the Texas MFCU, OIG, and FBI.
- **Texas**—Oliver Nkuku, a manager for K.O. Medical, Inc. (K.O.), and Callistus Edozie, a K.O. delivery person, were sentenced to 120 months and 41 months of incarceration, respectively, and ordered to pay \$453,112 and \$80,000 in restitution, jointly and severally, for their roles in a DME fraud scheme. In 2007, Nkuku, submitted fraudulent claims to Medicare on behalf of K.O. for power wheelchairs and other DME that were medically unnecessary, and Edozie delivered medically unnecessary DME. The DME was billed as catastrophe-related in connection with Hurricanes Katrina, Rita, Ike, and Gustav, even though the Medicare beneficiaries had either never owned power wheelchairs at the time of these catastrophes, or had owned wheelchairs that were not subjected to damage during the hurricanes.

■ Practitioner

- **Puerto Rico**—Edgar Herran Garcia (Herran) was sentenced by the District of Puerto Rico to 18 months of incarceration, and ordered to pay a \$10,000 fine and \$3,544 in restitution after he pleaded guilty to four counts of misbranding of a drug with the intent to defraud. Herran, a former licensed nurse, allegedly presented himself as a physician in Puerto Rico, despite never having a license to practice medicine in that territory. Nonetheless, Herran purported to specialize in wound care and treated several Medicare beneficiaries who suffered from skin ulcers. Herran regularly provided patients with prescriptions for medications to treat skin ulcers. These pharmacy claims were paid by health care benefit programs, including Medicare Advantage Plans. When writing the fraudulent prescriptions, Herran used his expired U.S. Virgin Islands nursing license number, which matched that of a legitimate Puerto Rican physician with no knowledge or involvement in the scheme. This case involved OIG and FDA's Office of Criminal Investigations.

■ Physical Therapy Clinic

- **Michigan**—Bernice Brown, owner of Detroit-area physical therapy clinic Wayne County Therapeutic Inc. (WCT), and Daniel Smorynski, WCT vice president, were convicted on charges of health care fraud for their leading roles in a Medicare fraud scheme. Brown and Smorynski were sentenced to 12 years and 7 months and 9 years in prison, respectively, and were ordered to pay \$6.7 million in restitution jointly and severally. From October 2002 to April 2007, WCT submitted multiple claims to the Medicare program for physical therapy, occupational therapy, and psychotherapy services purportedly provided and supervised by WCT staff when, in fact, such services were not professionally provided or supervised. As part of the scheme, Brown purchased fake physical and occupational therapy files from third-party contractors who used cash kickbacks to induce Medicare beneficiaries to provide their Medicare numbers and sign false documentation making it appear as if they received therapy. Brown instructed her staff to create false documents to add to the fictitious medical files to make it appear that WCT therapists, who were licensed in the State and enrolled with Medicare, had performed the services. In addition, Brown and Smorynski directed WCT staff to call their clients. These phone calls were billed to Medicare as 45 to 50 minute in-person psychotherapy visits.

■ Laboratory

- **Oregon**—Northwest Mobile Services, LLC and Northwest Mobile Imaging (collectively, Northwest Mobile) agreed to pay \$950,000 to settle allegations of utilizing unlicensed/unqualified x-ray technicians to provide x-ray services. Between January 2003 and July 2007, Northwest Mobile allegedly caused claims to be submitted to the Medicare program for services provided by x-ray

technicians that did not meet formal education requirements for x-ray technicians.

■ Home Health Services

- **Mississippi**—Telandra Jones and Theddis Pearson, owners of Statewide Physical Medicine (Statewide), were each sentenced to 120 months of incarceration and ordered to pay \$18 million in restitution, jointly and severally, for making false statements relating to a health care matter, theft of Government funds, and conspiracy to commit money laundering. Between 2001 and 2004, Statewide submitted false claims for in-home physical therapy and physical medicine services to Medicare and Medicaid programs falsely purporting that the services had been rendered by a physician or a qualified employee under the physician's direct supervision when, in fact, they were not. Statewide also inflated the time billed by claiming that beneficiaries received as many as 10 hours of therapy per session.

■ Skilled Nursing Facility

- **Maine**—Judith Schickle pleaded guilty to one count of health care fraud and three counts of embezzlement from a health care benefit program. She was sentenced to 5 years of probation and ordered to pay \$79,767 in restitution. Between 2000 and 2005, Schickle received \$79,000 in wages and benefits to which she was not entitled. During the course of her employment, as a full-time bookkeeper at the Varney Crossing Nursing Home, Schickle provided herself with multiple unauthorized pay increases. Consequently, her hourly rate of pay increased from \$11.25 in 2000 to more than \$22.00 per hour by 2004. In addition, Schickle was paid for hours of leave and earned benefit time that greatly exceeded the amount of earned benefit time and other leave hours that she had accrued. Schickle reported the unauthorized earned benefit time under departments in which she did not work, including the nursing and housekeeping departments, which resulted in the submission of false cost reports by ManorCare and improper reimbursement to the Varney Crossing Nursing Home.

Medicaid Fraud Control Units

MFCUs are key partners in the fight against fraud, waste, and abuse in State Medicaid programs. In fiscal year (FY) 2010, HHS awarded \$193.6 million in Federal grant funds to 50 State MFCUs (including Washington, DC), which employed a total of 1,827 individuals.

Collectively, in FY 2010, MFCUs reported 13,210 investigations, of which 9,710 were related to Medicaid fraud and 3,500 were related to patient abuse and neglect, including patient funds cases. The cases resulted in 1,603 individuals being indicted or criminally charged, including 1,048 for fraud and 555 for patient abuse and neglect, including theft

from the personal funds accounts of nursing home patients. In total, 1,324 convictions were reported in FY 2010, of which 836 were related to Medicaid fraud and 488 were related to patient abuse and neglect, including patients' funds cases. Examples of joint investigations follow.

■ Joint Investigations

- **Michigan**—Specialized Pharmacy Services (Specialized) agreed to pay \$11.6 million and enter into a settlement agreement with the State of Michigan Attorney General's Office to settle liability under the FCA. The settlement resolves allegations that from 2002 to 2009, Specialized charged Medicaid a greater amount for prescription medications than it did private insurance companies by providing nursing homes the services of their consultant pharmacists at a rate well below market price. Under Michigan law, a pharmacy cannot bill Medicaid more than it customarily accepts from a private health insurer for prescription medications. This case was jointly investigated with the FBI and the Michigan MFCU.
- **Texas**—Muhammad Usman, owner of Royal Ambulance Service, Inc. (Royal Ambulance) and First Choice EMS, Inc. (First Choice), was sentenced to 15 years of incarceration and ordered to pay \$1.3 million in restitution after being convicted of 12 counts of health care fraud, conspiracy to commit health care fraud, and money laundering. Royal Ambulance and First Choice provided medically unnecessary transports of Medicare and Medicaid beneficiaries to and from dialysis treatments. This case was investigated jointly with the Internal Revenue Service (IRS), FBI, the Texas MFCU, and the Office of Personnel Management (OPM).
- **Indiana**—Ali Abdelaziz Ahmed, owner of United Transportation (United), pleaded guilty to health care fraud and was ordered to pay restitution in the amount of \$42,668. United and Ahmed had been under investigation, along with numerous other subjects, for upcoding ambulatory transportation services as wheelchair van transports. This upcoding scheme paid the provider twice the amount it should have received as reimbursement for the services provided. This case was jointly investigated with the Indiana MFCU.

Provider Self-Disclosure Protocol

OIG is committed to assisting health care providers and suppliers in detecting and preventing fraudulent and abusive practices. Since 1998, we have made available comprehensive guidelines describing the process for providers to voluntarily submit to OIG self-disclosures of fraud, waste, or abuse. The Provider Self-Disclosure Protocol gives providers an opportunity to minimize the potential costs and disruption that a full-scale OIG audit or investigation might entail if fraud is uncovered. In doing so, the

self-disclosure also enables the provider to negotiate a fair monetary settlement and potentially avoid being excluded from participation in Federal health care programs.

The protocol guides providers and suppliers through the process of structuring a disclosure to OIG about matters that constitute potential violations of Federal laws (as opposed to honest mistakes that may have resulted in overpayments). After making an initial disclosure, the provider or supplier is expected to thoroughly investigate the nature and cause of the matters uncovered and make a reliable assessment of their economic impact (e.g., an estimate of the losses to Federal health care programs). OIG evaluates the reported results of each internal investigation to determine the appropriate course of action.

■ Self-Disclosure Guidance to Health Care Providers

The self-disclosure guidelines are available on the OIG Web site at <http://www.oig.hhs.gov/fraud/selfdisclosure.asp>.

See also: Open Letters at <http://www.oig.hhs.gov/fraud/openletters.asp>

■ Self-Disclosure Cases

During this reporting period, self-disclosure cases resulted in \$11.2 million in HHS receivables. Examples of self-disclosure cases follow.

- **California**—Santa Clara Valley Medical Center (SCVMC), agreed to pay \$4.3 million to resolve its liability under the FCA in connection with improper billing for 1-day hospital admissions that did not meet medical necessity criteria for inpatient services. SCVMC is an acute-care hospital owned and operated by the County of Santa Clara, California. SCVMC disclosed that it had billed Medicare and Medi-Cal for 1-day inpatient hospital stays which, instead, should have been billed as outpatient observation services.
- **Kentucky**—St. Elizabeth Medical Center (St. Elizabeth) agreed to pay \$1.2 million to resolve its liability under the civil monetary penalties law and the Stark Law. On January 23, 2009, St. Elizabeth disclosed an improper billing arrangement for provider-based services involving a rural vascular outreach program that had occurred at one of the St. Luke Hospitals prior to its merger with St. Elizabeth. St. Elizabeth also disclosed several improper financial relationships between St. Luke and a referring physician involving the provision of free and below-fair-market-value space and support services without written agreements, which created potential liability under the Stark Law and the anti-kickback statute.
- **North Dakota**—Mercy Medical Center (Mercy) agreed to pay \$88,331 to resolve its liability under the civil monetary penalties law. Mercy disclosed that it employed a staffer who was excluded from the Medicare program. The staffer was hired by Mercy in January 2008 to work as a Licensed Practical Nurse in the

Kidney Dialysis Unit (KDU), where the staffer remained until September 2009. St. Alexius Medical Center, which leased space from Mercy and used Mercy staff to operate the KDU, submitted multiple claims to Medicare for work that had been completed by the excluded staffer.

Office of Inspector General Administrative Sanctions

During this reporting period, OIG imposed 902 administrative sanctions. OIG has the authority to impose administrative sanctions for fraud or abuse or other activities that pose a risk to Federal health care programs and their beneficiaries (see Appendix D for an explanation of OIG's sanction authorities). These sanctions include the exclusion of individuals and entities from Federal health care programs and the imposition of civil monetary penalties for submitting false or fraudulent claims to a Federal health care program or for violating the anti-kickback statute, the Stark Law, or the Emergency Medical Treatment and Active Labor Act (EMTALA or patient dumping statute). Examples of administrative sanctions follow.

■ Program Exclusions

During this semiannual reporting period, OIG excluded 883 individuals and entities from Medicare, Medicaid, and other Federal health care programs. Most of the exclusions resulted from convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of license revocation. See on the Web: <http://exclusions.oig.hhs.gov/>. Examples of exclusions follow.

- **District of Columbia**—The U.S. District Court for the District of Columbia affirmed OIG's determination to exclude former Purdue Frederick Co. executives Michael Freidman, Paul Goldenheim, M.D., and Howard Udell from participation in Federal health care programs for 15 years. The exclusions were based on the executives' convictions for their failure – as responsible corporate officers – to prevent or correct the fraudulent misbranding and distribution of OxyContin. Michael Freidman is the former Chief Operating Officer and Chief Executive Officer, Paul Goldenheim is the former Chief Scientific Officer, and Howard Udell is the former General Counsel at Purdue Frederick.
- **Kentucky**—Tammy Brewer, an emergency medical technician, was excluded for a minimum of 25 years based on her conviction for manslaughter. While under the influence of Methadone, Brewer was driving an ambulance and swerved off the road striking a utility pole and chain link fence. The collision caused blunt force trauma to the patient that she was transporting, which caused the patient's death. Brewer was sentenced to 10 years of incarceration. The Kentucky Board of Emergency Medical Services revoked her license to practice as an emergency medical technician.
- **Pennsylvania**—John Kristofic, a physician, was excluded for a minimum of 20 years based on his health care fraud conviction. Over a 5-year period,

Kristofic submitted false and fraudulent claims to Medicare, TRICARE, the Federal Employee Health Benefit (FEHB) program, and private insurers for treatment and services which were not rendered because Kristofic was not in the office or the patients were being treated by other physicians on the dates claimed. Kristofic was sentenced to 1 year and 1 day of incarceration and ordered to pay \$1 million in restitution.

- **Mississippi**—Melinda Busby, a registered nurse, was excluded for a minimum of 14 years based on her felony conviction related to the unlawful distribution of controlled substances. Over a 2-year period, Busby conspired to possess and distribute in excess of 50 grams of a substance containing a detectable amount of methamphetamine, which is a Schedule II controlled substance. Busby was sentenced to 121 months of incarceration and surrendered her license to practice as a registered nurse to the Mississippi State Board of Nursing.
- **California**—Anthony Tun Lee, a medical doctor, was excluded for a minimum of 13 years based on his felony conviction for sexually assaulting a patient under his care. Lee subjected a 16-year-old patient to inappropriate touching during her examination, and represented that this touching served a professional purpose. Lee was sentenced to 3 years of incarceration. In addition, the Pennsylvania State Board of Medicine and the New York State Board of Professional Medical Conduct accepted the surrender of his medical licenses in those States.

■ **Corporate Integrity Agreements**

OIG assists DOJ in bringing and settling cases under the FCA. Many providers elect to settle their cases prior to litigation. As part of their settlements, providers often agree to enter into corporate integrity agreements with OIG to avoid exclusions from Medicare, Medicaid, and other Federal health care programs. Such agreements are monitored by OIG and require the providers to enhance existing compliance programs or establish new ones. The compliance programs are designed, in part, to prevent a recurrence of the underlying fraudulent conduct.

■ **Civil Monetary Penalties Law**

The civil monetary penalties law authorizes OIG to impose administrative penalties and assessments against a person who, among other things, submits or causes to be submitted claims to a Federal health care program that the person knows or should know are false or fraudulent. During this reporting period, OIG concluded cases involving more than \$4.5 million in penalties and assessments.

- **North Carolina**—Long Term Care, Inc. (LTC), a durable medical supplier, agreed to pay \$170,000 to resolve its liability under the civil monetary penalties law. LTC employed an excluded individual over a period of 4 years. LTC hired the excluded individual through a contract arrangement with a professional

employment organization that provided human resources and staffing support to LTC.

- **Florida**—Orthopedic surgeon Steven J. Lancaster agreed to pay \$101,000 to resolve his civil monetary penalty liability for allegedly soliciting kickbacks from a medical device manufacturer. The Government contends that Lancaster offered to leverage his product usage and ability to influence purchasing decisions through his position as Chief of Orthopedics at Baptist Medical Center Beaches Hospital in exchange for a personal services contract worth a guaranteed \$40,000.

■ Patient Dumping

Some of the civil monetary penalty cases that OIG resolved between October 1, 2010, and March 31, 2011, were pursued under EMTALA, a statute designed to ensure patient access to appropriate emergency medical services.

- **Alabama**—Mobile Infirmary paid \$45,000 to resolve allegations that it improperly refused to accept a patient transferred from another hospital. The patient came to the transferring hospital's emergency room complaining of severe abdominal pain and required immediate specialized surgical intervention not available at the hospital. Mobile Infirmary allegedly refused to accept the transfer even though it had the capacity and specialized capabilities to treat the patient's condition. Ultimately, the patient was transferred to a hospital 60 miles away. The patient's condition deteriorated en route and he had to be transported by Life Flight helicopter to the receiving hospital, where he later died.
- **Texas**—Houston Northwest Medical Center (Houston Northwest) paid \$40,000 to resolve allegations that it failed to provide an appropriate medical screening examination or stabilizing treatment and inappropriately transferred a pregnant woman who came to Houston Northwest while having contractions. Houston Northwest transferred the patient by ambulance to a hospital nearly 2 hours away; however she went into active labor en route and was diverted to a closer hospital.
- **Georgia**—North Fulton Regional Hospital (North Fulton), a hospital located in Roswell, Georgia, agreed to pay \$40,000 to resolve allegations that it failed to provide a medical screening examination for a pregnant patient. The patient, who was 30 weeks pregnant, reported to the hospital's emergency department upon the advice of her physician after she experienced labor pains. North Fulton is a part of the Tenet Healthcare Corporation, which disclosed the conduct to the OIG under its corporate integrity agreement.
- **Florida**—Port St. Lucie Hospital (Port St. Lucie) paid \$19,000 to resolve allegations that it refused to accept a patient from a transferring hospital. Port

St. Lucie is an inpatient mental health facility. A nurse at Port St. Lucie allegedly refused to accept the transfer of a patient with acute psychosis because the nurse believed the patient was uninsured.