No. 215

Chapter 610
Billing for Items or Services Not Rendered

Contents

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Chapter 610
Billing for Items or Services Not Rendered

Overview

One of the most common types of Medicare and Medicaid fraud involves billing for items not provided or services not rendered as claimed. Variations include billing for nonexistent items or services, misrepresenting the quality of services rendered, and misrepresenting noncovered services as covered to obtain reimbursement. In some cases, providers create fictitious supporting documentation to hide fraudulent billing practices.

This chapter addresses legal and regulatory requirements imposed by the Centers for Medicare & Medicaid Services (CMS), compliance guidance issued by the Department of Health and Human Services Office of Inspector General (OIG), and enforcement issues applicable to various types of providers. For information on criminal prosecution and civil monetary penalties, see *Chapter 210, Penalties*.

610.10 Law and Regulatory Summary

610.10.10
General Issues

Among the more common types of Medicare fraud is billing for items not provided or services not rendered as claimed. Such practices include billing for nonexistent services and supplies, misrepresenting noncovered services as covered in order to obtain Medicare reimbursement, and billing for treatment using codes that are mutually exclusive or medically unlikely. Billing for services not rendered also includes billing for services rendered in a worthless or nearly worthless manner.[1] Indeed, qui tam relators (whistleblowers) have brought False Claims Act (FCA) suits alleging that hospitals[2] and nursing homes improperly billed for providing substandard care.[3]

Another fraudulent practice, "upcoding," also falls under the prohibition against billing for services not rendered. Upcoding is falsely reporting the type, duration, or complexity of a service or procedure in order to maximize reimbursement. For a comprehensive discussion, see *Chapter 620, Upcoding*.

610.10.20
"Reasonable" Requirement

The prohibition against billing for items or services not provided or rendered as claimed stems from the Social Security Act, which states that no payments can be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."[4]

Claims based on items or services that were not provided are unreasonable on their face and, therefore, are considered false under the FCA.

610.10.30
Documentation

The healthcare provider must prove that items or services were rendered as claimed and payment is due. Under Medicare, no payment is authorized unless the claim includes sufficient information to prove that services or supplies were provided.[5]

As a result, comprehensive documentation of all claimed services and supplies is essential, not only to ensure reimbursement, but also to avoid charges of fraud in connection with billing practices.

CMS regulations require Medicare providers to establish and maintain records for every patient, and document the services or supplies provided.[6] In addition, providers must allow CMS or the OIG access to such records for the purpose of determining whether claimed services or supplies actually were rendered. Failure to grant such access is grounds for exclusion from Medicare.[7]

According to the OIG,[8] depending on the circumstances, proper documentation can include:

- reason for the patient encounter;
- appropriate history and evaluation;
- documentation of all services;
- reasons for the services;
- ongoing assessment of the patient's condition;

[1] *See* United States ex rel. Lee v. Smithkline Beecham, Inc., 245 F.3d 1048 (9th Cir. 2001).
[2] *See* United States ex rel. Raymer v. University of Chicago Hospitals (N.D. Ill., Feb. 28, 2006).
[3] *See, e.g.,* cases discussed at *Enforcement,* § 610.30.
[4] Social Security Act § 1862 [42 U.S.C. § 1395y(a)(1)(A)].
[5] Social Security Act § 1833(e) [42 U.S.C. § 1395l(e)].
[6] *See, e.g.*, 42 C.F.R. §§ 482.24 (hospitals), 484.48 (home health agencies), and 491.10 (rural health clinics).
[7] 42 C.F.R. § 1001.1301.
[8] Office of Inspector Gen. (OIG), U.S. Dep't. of Health and Human Servs., Compliance Program Guidance for Third-Party Medical Billing Companies, 63 Fed. Reg. 70,138, 70,144 n.50 (Dec. 18, 1998).

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- information on patient progress and treatment outcome;
- treatment plan;
- plan of care, including treatments, medications (including dosage and frequency), referrals, patient and family education, and follow-up care;
- changes in treatment plan;
- medical rationale for the services rendered;
- support for medical necessity, e.g., certificates of medical necessity for durable medical equipment;
- abnormal test results;
- relevant health risk factors;
- support for evaluation and management codes billed;
- dated and authenticated medical records; and
- prescriptions.

610.20 Industry Compliance Guidelines

610.20.10
Introduction

Billing for items not provided or services not rendered as claimed is one of the most common types of Medicare fraud. Such fraudulent practices can take a variety of forms, including billing for:

- nonexistent services and patients, supported by purchased or fraudulently obtained beneficiary numbers or fictitious medical records;
- nonexistent durable medical equipment or other supplies, supported by forged purchase documentation;
- services that were not provided because patients failed to keep their appointments—that is, no-shows;[9]
- a practice known as "looping," which is done to get around a given patient's maximum benefits and involves billing in the name of the patient until his or her benefits run out and then billing in the name of the eligible spouse even though such services were not actually provided to the spouse;
- noncovered services and supplies as covered services and supplies—for example, performing toenail clipping, which is a noncovered foot care service, but billing for toenail removal, which is a covered foot care service; and
- "gang visits" by a medical professional, where large numbers of nursing facility residents are seen in a single day.

Closely related are CMS coding edits that guard against paying for services that could not have been rendered as claimed. CMS developed the National Correct Coding Initiative (NCCI) to promote correct coding methodologies and control improper coding leading to inappropriate payments.[10] An example is when the repair of an organ can be performed by two different methods. As both cannot occur at the same time, only one repair method must be chosen and reported. A second example is reporting an "initial" service and "subsequent" service for the same time. These code pairs should not be reported together.

"Medically unlikely edits" (MUEs) are applicable only to a single provider and a single beneficiary on the same service date. MUEs are a claims review process designed to limit the frequency with which individual Current Procedural Terminology (CPT) codes are billed and often are based on the anatomy of the body. For example, only one appendix can be removed from an individual on one day, so claims indicating a greater frequency will not be paid. Only a small number of CPT codes have an associated MUE.[11]

610.20.20
Hospitals

In its compliance program guidance for hospitals, the OIG identifies billing for items or services not rendered as a significant risk area.[12]

In addition to the specific legal requirements governing a hospital's maintenance of clinical records, the OIG advises hospitals to implement policies and procedures to ensure that only provided services or items are billed. According to the OIG, such policies and procedures should require:[13]

- proper and timely documentation of all physician and other professional services prior to billing, so that only accurate and properly documented services are billed;
- submission of claims only when appropriate supporting documentation exists, is maintained properly, and available for audit and review;
- appropriate organization of physician and hospital records and medical notes used as a basis for a claim submission so they can be audited and reviewed; and

[9] Centers for Medicare & Medicaid Servs. (CMS), U.S. Dep't of Health & Human Servs., Claims Processing Manual (Pub. 100-4), ch. 1, § 30.3.13.

[10] *See* CMS, National Correct Coding Initiative Edits.

[11] *See* CMS, Medically Unlikely Edits for frequently asked questions regarding MUEs.

[12] OIG, Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8990 (Feb. 23, 1998). This compliance guidance is still extremely relevant and the OIG continues to focus on hospitals billing for items or services not rendered as a significant risk area even 20 years after the guidance was first issued. *See also*, CMS, Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians.

[13] OIG, Compliance Program Guidance for Hospitals, 63 Fed. Reg. at 8991.

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- use of medical records and other documentation as the basis for the diagnosis and procedures reported on the reimbursement claim.

610.20.30
Nursing Homes

In a special fraud alert, the OIG identified fraudulent billing practices as a significant risk area for nursing homes, because they represent convenient patient pools that can be used to submit false claims, including those for supplies and services not rendered or not rendered as described.[14] A further example of the continuing focus that both OIG and DOJ have placed on enforcement in the skilled nursing home area can be seen in enforcement actions pursuant to the FCA resulting from either an outright failure to provide care or the provision of care that allegedly failed to conform to the standards contemplated in given billing codes.[15]

Common fraudulent billing schemes include:

- falsifying medical records to indicate that nonexistent services were rendered;
- manipulating billing codes to overstate the amount of time spent with a resident; and
- billing for covered services when routine, noncovered services actually are provided.

In addition, gang visits by one or more medical professionals—where large numbers of nursing home residents are seen in a single day—suggest fraudulent practices.[16] In its alert, the OIG stated that such visits indicate that the level of services provided might not be of sufficient duration or scope, consistent with the service billed to Medicare.

In its Supplemental Compliance Program Guidance for Nursing Facilities,[17] the OIG cited facilities that bill federal healthcare programs, including Medicare, for restorative and personal care services despite the fact that such services were not provided or were "so wholly deficient that they amounted to no care at all," rendering them unreimbursable. Billing for necessary restorative and personal care services not rendered may subject nursing facilities to liability under fraud and abuse statutes and regulations, the guidance said.

To avoid this risk, the OIG "strongly encouraged" nursing facilities to have comprehensive procedures in place to ensure that services are of an appropriate quality and level and that services are in fact delivered to nursing facility residents by engaging in resident and staff interviews; medical record reviews; consultations with attending physicians, the medical director, and consultant pharmacists; and personal observations of care delivery. Complete and contemporaneous documentation of services also is critical to ensuring that services are rendered, the guidance said.

610.20.40
Home Health Agencies

610.20.40.10
General Issues

The OIG's compliance guidance for home health agencies specifically cited billing for items or services not actually provided as a risk area for such entities.[18]

Home healthcare services are particularly susceptible to fraud, the OIG said, because:[19]

- beneficiaries make no copayments, except on medical equipment;
- beneficiaries do not receive explanations of benefits for bills submitted by home health agencies; and
- nonmedical personnel provide home health services with limited direct medical supervision.

610.20.40.20
Types of Fraudulent Activities

Billing for services not rendered as claimed can take several forms, such as submitting claims for visits that were not made or supplies that were not provided.[20] In some cases, this fraudulent practice involves creating fictitious supporting documentation by forging beneficiary signatures on visit slips or logs to verify services were performed.

To guard against this practice, the OIG recommends that home health agencies implement policies and procedures to verify that beneficiaries actually received the appropriate level and number of services billed.[21] This can be done by periodically contacting—either by mail, telephone, or in person—a random sample of patients and interviewing the clinical staff involved.

Billing for No-Shows. CMS cites billing Medicare for appointments that patients fail to keep as a form of billing fraud (services not rendered).[22]

Misrepresenting Services Rendered. Another fraudulent practice involves misrepresenting the nature of furnished services.[23] This includes describing a noncovered service in a misleading way so that it appears as though a covered service was furnished (see *Nursing Homes,* § 610.20.30).

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[14] OIG Special Fraud Alert: Fraud and Abuse in the Provision of Services in Nursing Facilities, 61 Fed. Reg. 30,623, 30,624 (June 16, 1996).

[15] *See e.g.* United States, and the State of Tennessee's Complaint, United States v. Vanguard Healthcare, LLC, No. 3:16-cv-02380 (M.D. Tenn. Sept. 06, 2016).

[16] 61 Fed. Reg. 30,623, 30,624.

[17] OIG, Compliance Program Guidance for Nursing Facilities, 73 Fed. Reg. 56,832, 56,841 (Sept. 30, 2008).

[18] OIG, Compliance Program Guidance for Home Health Agencies, 63 Fed. Reg. 42,410, 42,414 (Aug. 7, 1998).

[19] OIG Special Fraud Alert: Home Health Fraud, 60 Fed. Reg. 40,847 (Aug. 10, 1995).

[20] OIG, Compliance Program Guidance for Home Health Agencies, 63 Fed. Reg. at 42,414.

[21] *Id.* at 42,416.

[22] CMS, Program Integrity Manual (Pub. 100-8), ch. 4, § 4.2.1.

[23] *Id.*

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610.20.40.30
Incentive-Based Compensation Programs

The OIG warns against compensation programs that offer incentives based on the number of visits performed and revenue generated.[24] Prior to enactment of the Balanced Budget Act of 1997, Medicare imposed no limits on the number of covered home health visits; as a result, incentives for productivity and volume of services sometimes led providers to bill for services not rendered to meet goals imposed by home health agency management. Medicare now imposes a 100-visit limit on Part A coverage for post-institutional home health services furnished to an individual enrolled in Part B during a home health spell of illness.[25]

610.20.40.40
Contractors

Medicare allows home health agencies to contract with other organizations to provide care to their patients. However, the OIG reminds home health agencies that they remain liable for all services provided by the subcontractor and billed to a federal healthcare program, and have a duty to monitor care provided by the subcontractor.[26]

610.20.50
Hospices

CMS cites billing for services not furnished and/or supplies not provided as a fraudulent practice.[27] CMS also considers falsely representing the nature of the service furnished to be a fraudulent practice.

610.20.60
Physicians

The OIG's compliance guidance for physicians continues to cite billing for items or services not rendered or provided as claimed as one of its most frequent subjects of investigations and audits.[28]

In the guidance, the OIG points out the importance of timely, accurate, and complete documentation. It notes that a properly documented medical record verifies and documents precisely what services actually were provided.

610.20.70
Clinical Laboratories

The compliance guidance for clinical laboratories identifies one risk area relevant to billing for services not rendered: submitting claims for tests that are not performed.[29] For example, if a laboratory did not perform an ordered test because of a laboratory accident or insufficient quantities of a specimen, submitting a claim to Medicare could subject the laboratory to sanctions. The OIG continues to place a special emphasis on clinical laboratories as a risk area, including them in their enforcement work plans for Fiscal Years 2015, 2016, and 2017.[30]

610.20.80
Durable Medical Equipment

In its guidance for the durable medical equipment, prosthetics, orthotics, and supply (DMEPOS) industry, the OIG identifies billing for items or services not provided as claimed as an area of concern.[31] The guidance states that this practice can take the form of:

- submitting a claim representing that the supplier of DMEPOS provided an item or service or part of an item or service that the beneficiary did not receive; or
- failing to fulfill a contractual agreement, such as failing to service rental equipment.

The OIG recommends that DMEPOS suppliers formulate written policies and procedures to ensure that claims are submitted only for items or services that are completed properly, accurately, and identified correctly.[32] Prior to submitting the claim, the DMEPOS supplier should take reasonable steps to ensure that the item or service being claimed was provided.

For mail order suppliers, the OIG recommends that they implement a tracking system to determine whether the beneficiary received the supplies.[33]

610.20.90
Third-Party Medical Billing Companies

610.20.90.10
General Issues

The OIG's guidance for third-party billing companies warns against a number of improper billing practices, including:[34]

- billing for items or services without actual documentation—that is, submitting a claim that cannot be substantiated in the documentation; and
- using computer software programs that encourage billing personnel to enter data in fields indi-

[24] OIG, Compliance Program Guidance for Home Health Agencies, 63 Fed. Reg. at 42,414.

[25] Social Security Act § § 1812(a)(3),(b)(3) [42 U.S.C. § § 1395d(a)(3), (b)(3)].

[26] OIG Special Fraud Alert: Home Health Fraud, 60 Fed. Reg. at 40,848.

[27] CMS, Medicare General Information, Eligibility and Entitlement Manual (Pub. 100-1), ch. 1, § 20.3.1.

[28] OIG, Compliance Program for Individual and Small Group Physician Practices, 65 Fed. Reg. 59,434, 59,439 (Oct. 5, 2000).

[29] OIG, Compliance Program Guidance for Clinical Laboratories, 63 Fed. Reg. 45,076, 45,080 (Aug. 26, 1998).

[30] OIG, Fiscal Year 2017 Work Plan at 15; Fiscal Year 2016 Work Plan at 18; and Fiscal Year 2015 Work Plan at 16.

[31] OIG, Compliance Program Guidance for the Durable Medical Equipment, Prosthetics, Orthotics and Supply Industry, 64 Fed. Reg. 36,368, 36,372 n.30 (July 6, 1999).

[32] *Id.* at 36,377.

[33] *Id.* § II.A.3.g Mail Order Suppliers.

[34] OIG, Compliance Program Guidance for Third-Party Medical Billing Companies, 63 Fed. Reg. at 70,142 n.27.

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cating services were rendered even though they were not actually performed or documented.

610.20.90.20

Proper Documentation

In its compliance guidance, the OIG stresses the importance of proper documentation for billing companies that provide coding services. Specifically, the OIG urges such billing companies to:[35]

- obtain proper and timely documentation of all physician and other professional services prior to billing;
- submit claims only when supporting documentation exists and is organized appropriately and available for audit and review;
- base diagnoses and procedures reported in the reimbursement claim on medical records and other documentation;
- make documentation necessary for accurate code assignment available to coding staff at the time of coding;
- establish a process for pre- and post-submission review of claims to ensure that they accurately represent the services provided, are supported by sufficient documentation, and conform with applicable coverage criteria; and
- obtain clarification from the provider when documentation is confusing or lacks adequate justification.

The OIG notes that, although documentation is the responsibility of the healthcare provider, the coder should be aware of documentation requirements and encourage providers to document services appropriately.[36]

610.30 Enforcement

610.30.10

Introduction

Both CMS and the OIG issue Medicare fraud alerts. For CMS, the most commonly issued fraud alert is the National Medicare Fraud Alert (NMFA), issued for educational and informational purposes only and intended to assist interested parties in obtaining additional information concerning potential fraud and to alert affected parties to the nature of the suspected fraud.[37] The NMFAs do not identify specific providers or entities suspected of committing fraud, but instead serve as a fraud detection lead in regard to a particular scheme or scam. The CMS central office issues an NMFA when a fraudulent or abusive activity is perceived to be, or has the potential for being, widespread—that is, has crossed over from one program integrity contractor zone (ZPIC) or into the jurisdiction of other program safeguard contractors (PSCs). The alerts are not intended to be used as a basis for denial of claims or any adverse action against any provider or supplier. Such decisions must be made based on facts developed independent of any alert.

CMS also issues restricted fraud alerts (RFAs) when a specific provider is suspected of engaging in fraudulent or abusive practices. PSC and ZPIC benefit integrity (BI) units prepare this type of alert to advise Medicare carriers; intermediaries; the FBI; the OIG; Department of Justice; PSCs; ZPICs; U.S. Postal Service; IRS; the Offices of the U.S. Attorney; and others of a particular provider or providers suspected of fraud.

The OIG's fraud alerts are published on its website[38] and are also available on BNA's Health Law Resource Center and Bloomberg Law. The OIG also devotes significant resources to the investigation of fraud committed against the Medicare and Medicaid programs, often in conjunction with other law enforcement entities, such as the FBI, IRS, U.S. Postal Inspection Service, and State Medicaid Fraud Control Units (MFCUs), and announces some of these efforts in its Work Plan. Historically, the OIG updated its work plan annually or semiannually; however, in June 2017, the OIG announced its intent to update its work plan on its website monthly in order to allow providers to more timely identify and respond to emerging fraud and abuse issues.[39] In the Fiscal Year 2010 Work Plan, for example, the OIG said it would investigate individuals, facilities, or entities that bill or are alleged to have billed Medicare and/or Medicaid for services not rendered, not rendered as prescribed, or for substandard care that is so deficient that it constitutes a "failure of care."[40]

The OIG also issues semiannual reports to inform Congress of OIG activities and accomplishments. Its report from 2016,[41] for example, said that during the first half of FY 2016, OIG reported expected recoveries of more than $2.77 billion, which includes audit receivables and investigative receivables. In its 2017 report, the OIG reported expected recoveries of $4.4 billion. The report showed that for FY 2017, $296.4 million would be returned based on program audit findings, while approximately $4.1 billion is expected in "investigative" receivables. Semiannual reports also give the details of certain cases that have been resolved. Recent examples involving billing for services not rendered are included below by type of healthcare entity.

[35] *Id.* at 70,144.
[36] *Id.* at n.50.
[37] CMS, Program Integrity Manual (Pub. 100-8), ch. 4.
[38] OIG, Special Fraud Alerts.
[39] *See* OIG, Work Plan.
[40] OIG, Fiscal Year 2010 Work Plan at 67-68.
[41] OIG, Semiannual Report October 1, 2015 - March 31, 2016, at iv.

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610.30.20
OIG Enforcement Priorities

610.30.20.10
Hospitals

The FCA remains the primary enforcement tool utilized by the federal government in the recovery of funds improperly paid out by the government to private entities. Healthcare companies, including hospitals, constituted the largest portion of those recoveries weighing in at $2.5 billion in 2016.[42] As such, hospitals remain primary targets for FCA recoveries and prosecutions. In 2016, Tenet Healthcare Corporation paid the federal government $244.2 million to resolve allegations that four of its hospitals paid kickbacks for patient referrals. In addition, Tenet paid two state Medicaid programs another $123.7 million and two of Tenant's subsidiaries paid another $145 million on related charges bringing the total recoveries from Tenet alone to $513 million.[43]

In addition to the usual coding and chart reviews, the OIG included a few wrinkles in their Fiscal Year 2017 Work Plan and enforcement planning.

Section 2702 of the Affordable Care Act prohibits payment for provider preventable conditions.[44] The implementing regulations of the Act define a "healthcare-acquired condition" as a "condition occurring in any inpatient hospital setting" that meets the criteria contained in the Act.[45] The OIG Work Plan for Fiscal Year 2017 includes reviews of state Medicaid programs for provider preventable conditions.[46] One can logically assume the end result of this focus will be stepped up reviews of hospital system claims by state Medicaid programs for claims potentially related to these conditions. In addition, given the current enforcement atmosphere that seems to characterize any billing error as fraud, any claims found to be potentially related to provider preventable conditions will potentially be pursed under the FCA.

In its "2017 Year in Review" the Fraud Section of the DOJ's Criminal Division announced the launch of its Health Care Fraud Data Analytics Team.[47] This appears to be an effort to enhance fraud detection and enforcement actions by U.S. Attorney's Offices via enhanced use of data analytics. These efforts will almost certainly increase the scrutiny that hospital billing departments find themselves subject to.

610.30.20.20
Nursing Homes and Residential Facilities

The OIG has long recognized that nursing facilities and their residents are common targets for fraudulent schemes by which healthcare providers, medical professionals, nursing facility staff, and others improperly bill Medicare and Medicaid for medically unnecessary services and services either not rendered or not rendered as described.[48]

The OIG said in 2007 that it would increase its attention to quality-of-care issues for beneficiaries residing in nursing facilities. "All too often, Medicare and Medicaid programs are improperly billed for medically unnecessary services and for services either not rendered or not rendered as prescribed," sometimes including allegations of patient abuse or neglect.[49] The 2007 work plan said the OIG would work jointly with federal, state, and local law enforcement and regulatory agencies to resolve any allegations of patient abuse or neglect uncovered by its investigations. Evidence that this focus continues may be found in 2016 statements by Inspector General Daniel R. Levinson of the U.S. Department of Health and Human Services indicating that these "recoveries benefit vulnerable citizens in Medicare and Medicaid."[50]

In January 2016, contract therapy providers RehabCare Group, Inc., RehabCare Group East, Inc., and their parent company, Kindred Healthcare, Inc., paid a total of $125 million to resolve civil FCA allegations that they caused the submission of false claims to Medicare for rehabilitation services that were not reasonable, necessary, or that never occurred. The government alleged, inter alia, the providers routinely scheduled unreasonably high levels of therapy irrespective of the clinical needs of the patients.[51]

610.30.20.30
Physicians and Other Individual Providers

Medicare (and Medicaid) Administrative Contractors are actively monitoring billings by physicians and other individual providers. They are doing so through various means, including data mining, which relies on Medicare billing statistics to look for "outliers"—billing patterns that deviate substantially from the norm. Where suspected aberrations are found, the contractors are not only implementing prepayment reviews and postpayment audits but are also referring cases of suspected fraud and abuse to the OIG, which can result in criminal and civil investigations.

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[42] U.S. Dep't of Justice, Fraud Statistics, Oct. 1, 1987 to Sept. 30, 2016.

[43] *See* Settlement Agreement in United States ex rel. Williams v. Health Mgmt. Assocs., No. 3:09-cv-00130 (M.D. Ga. Sept. 30, 2016).

[44] 42 U.S.C. § 1396b-1.

[45] 42 C.F.R. § 447.26.

[46] OIG, Fiscal Year 2017 Work Plan.

[47] U.S. Dep't of Justice, Fraud Section Year in Review at 10.

[48] OIG, Semiannual Report October 1, 2000 -March 31, 2001, at 29.

[49] OIG, Fiscal Year 2007 Work Plan at 45.

[50] DOJ Press Release, Justice Department Recovers Over $4.7 Billion From False Claims Act Cases in Fiscal Year 2016.

[51] *See* Settlement Agreement in United States ex rel Halpin v. Kindred Healthcare Inc, No. 1:11-cv-12139 (D. Mass. Jan. 16, 2016).

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An OIG audit report from April 2009 said that Medicare paid $97.6 million for evaluation and management (E&M) services that were included in eye global surgery fees but not provided during the global surgery periods in calendar year 2005.[52] Global surgery fees include payment for a surgical service and the related preoperative and postoperative E&M services provided during the global surgery period, which extends from the day before the surgery to 90 days after the surgery. The OIG recommended that CMS consider adjusting the estimated number of E&M services to better reflect the number of such services actually being provided to beneficiaries or using the financial results of its audit in conjunction with other information during the annual update of the physician fee schedule. CMS responded that it would be more prudent to conduct further analysis before proposing any changes in the number of E&M services.

The OIG has continuously targeted physicians and other individual healthcare practitioners through criminal convictions and settlements.[53]

610.30.20.40
Home Health Agencies

A national federal crackdown on Medicare fraud by the Medicare Fraud Strike Force, a joint initiative between the U.S. Department of Justice and U.S. Department of Health & Human Services, uncovered in February 2011 an egregious example of a fraudulent home health scheme. Twenty-one defendants including two doctors, six nurses, eleven patient recruiters, and two employees were indicted for their roles in a $25 million Medicare billing scheme involving two Florida companies, ABC Home Health Care Inc. and Florida Home Health Care Providers Inc., that existed only to defraud Medicare, federal officials said.[54] The two companies fraudulently billed Medicare for home health services provided to beneficiaries who were not restricted to their homes and who had no medical necessity for the services. The scheme also entailed submitting false nursing notes for services that were unnecessary or not rendered and receiving money for recruited patients. [55]

All of the defendants pleaded guilty to charges of conspiracy to commit healthcare fraud and have been sentenced for their roles in the scheme. The sentences ranged from 78 months in prison and $15.3 million in restitution for the office manager of one of the companies, who taught the owners and operators how to operate a fraudulent home health agency, negotiated kickback payment rates between patient recruiters and the company, distributed the kickbacks, taught nurses how to falsify patient files to make it appear that Medicare beneficiaries qualified for home health care and therapy services, and recruited patients for the scheme;[56] 40 months in prison and $1.1 million in restitution for the lead defendant, a physician who operated two medical offices and referred patients to the agencies, falsified patient files with descriptions of nonexistent medical conditions, and issued prescriptions and plans of care for medically unnecessary therapy;[57] and 24-month prison terms and restitution of $296,000 and $395,000 for two nurses who received kickbacks and bribes from the company for recruiting Medicare beneficiaries who would allow the companies to bill Medicare for services that were unnecessary and/or never provided;[58] to sentences of 6 to 18 months in prison and restitution of $118,000 to $390,000 for several patient recruiters who knew the patients they recruited did not qualify for the services billed to Medicare.

In its 2016 Semiannual Report, the OIG highlighted settlements with home health agencies, one being for $3.7 million where the agency submitted false claims to Medicaid for personal care services that were not provided, not provided pursuant to appropriate supervision, or not medically necessary.[59] The agreement also resolved allegations that the agency paid patient recruiters for referrals of patients. The company and its owner were excluded from participating in federal healthcare programs for 15 years.[60]

610.30.10.50
Deceased Beneficiaries

In both 2009 and 2010, the OIG reported it would be investigating Part D sponsors for charges made for deceased beneficiaries and said it would review payments to Medicare Advantage plans for enrollees who died.[61]

In its fall 2011 semiannual report, the OIG reported that the owner and operator of a Florida pharmacy was sentenced to 52 months' incarceration and ordered to pay $3.9 million in restitution for healthcare fraud. Between August 2006 and April 2007, the owner used the pharmacy to submit false and fraudulent claims to Medicare, including claims for deceased beneficiaries. These claims sought reimbursement for the cost of DME, prescription medications, and other items and

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[52] Office of Audit Services, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Nationwide Review of Evaluation and Management Services Included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005 (No. A-05-07-00077, April 20, 2009), *available at* oig.hhs.gov.

[53] *See Settlement Agreements,* § 610.30.30 and *Court Rulings,* § 610.30.40.

[54] United States v. Nunez, No. 1:11-20113 (S.D. Fla. Feb. 11, 2011).

[55] *Id.*

[56] OIG, Semiannual Report October 1, 2011- March 31, 2012, at III-5.

[57] *South Florida Physician, Nurses Sentenced In $25 Million Home Health Billing Scheme*,15 BNA's Health Fraud Rep. 998 (Dec. 14, 2011).

[58] *Id.*

[59] OIG, Semiannual Report October 1, 2015 - March 31, 2016, at 14.

[60] OIG, Semiannual Report October 1, 2015 - March 31, 2016, at 14.

[61] OIG, Fiscal Year 2010 Work Plan at 38; OIG, Fiscal Year 2009 Work Plan at 40 and 31.

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services for Medicare beneficiaries in Florida that were not prescribed by doctors or provided as claimed.[62]

The OIG also reported in its fall 2011 semiannual report that for the period January 2006 through December 2007, Medicare made approximately $3.6 million of unallowable payments on behalf of deceased Medicare enrollees to prescription drug plan sponsors for coverage periods after the enrollees' months of death.[63] A May 2011 OIG audit report found that CMS's systems categorized these enrollees as alive or as having different dates of death than those listed in the Social Security Administration's files.[64]

Although the audit report found that CMS had correctly stopped payments for the vast majority of deceased enrollees, its systems did not always identify and prevent the improper payments. In addition, CMS did not always recover payments made on behalf of deceased enrollees on a timely basis. The report recommended that CMS recoup the $3.6 million, recover improper payments in a timely manner, and implement system enhancements to prevent and detect future improper payments for deceased enrollees.

In it's 2017 Work Plan, the OIG reported that it would add a review of prospective payments made under Medicare Part C to Medicare Advantage companies related to deceased beneficiaries. A prior OIG review of payments made on behalf of deceased beneficiaries found that CMS had improperly paid the MA companies $20 million that were made after the beneficiaries death.[65]

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Settlement Agreements

Settlement	Alleged Misconduct	Resolution and Penalties
United States ex rel. Wheeler v. Union Treatment Ctrs., No.5:13-cv-00004 (W.D. Tex. settlement agreement announced June 7, 2017).	From 2009 through 2012, a therapy provider fraudulently overcharged the Office of Workers' Compensation programs for services and supplies it did not provide. The provider promoted itself to individuals who were injured on the job and targeted unionized postal workers and U.S. Army employees.	The provider agreed to pay $3 million, forfeit claims for payment exceeding $1.6 million, and be permanently excluded from participating in federal healthcare programs to resolve the allegations. See 110 *BNA's Health Care Daily Report* (June 9, 2017).
United States ex rel. Shindler v. Valley Tumor Med. Grp., No. CV15-2249 (C.D. Cal. settlement agreement announced May 9, 2017).	From 2006 through 2015, a radiation therapy center billed Medicare, Medi-Cal and TRICARE for more than 20,000 radiation procedures that were performed by unsupervised technicians.	The therapy center agreed to pay $3 million to resolve the allegations. See 21 *BNA's Health Care Fraud Report* 330 (May 24, 2017).
United States ex rel. Bookwalter v. UPMC, No. 12-cv-145 (W.D. Pa. settlement agreement announced July 27, 2016).	Several neurosurgeons at a hospital submitted claims to Medicare for surgical procedures that require a certain level of supervision that was not, in fact, provided, and one neurosurgeon submitted claims for surgeries that were never performed.	The hospital agreed to pay $2.5 million to resolve the allegations. See 146 *BNA's Health Care Daily Report* (July 29, 2016).
United States v. Riachi, No. 2:16-cv-00730 (D.N.J. settlement agreement announced Feb. 12, 2016).	A doctor and two companies he owned routinely billed Medicare and Medicaid for anorectal manometry, an invasive diagnostic test, and electromyography, even though most of the tests were never performed, and billed Medicare for physical therapy services that were not performed by a qualified therapist.	The doctor and companies agreed to pay $5.25 million to resolve the allegations. See 31 *BNA's Health Care Daily Report* (Feb. 17, 2016).

[62] OIG, Semiannual Report April 1- September 30, 2011, at III-5.]

[63] OIG, Semiannual Report April 1 - September 30, 2011, at I-10.

[64] OIG Audit Report, Review of Medicare Payments to Prescription Drug Plans on Behalf of Deceased Enrollees (A-05-09-00027).

[65] OIG, Fiscal Year 2017 Work Plan at 28.

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Settlement	Alleged Misconduct	Resolution and Penalties
WELLHealth and Topical Specialists (settlement announced Feb. 11, 2016).	Four physicians and a pharmacist at an existing pharmacy were involved in creating a sham pharmacy, which was unable to obtain separate contracts with the government healthcare programs, and so the physicians funneled prescriptions from the sham pharmacy to the existing pharmacy, which in turn billed TRICARE for the prescriptions. The four physicians wrote hundreds of prescriptions for pain and scar creams that were often not used by patients. In some instances the physicians recruited other physicians to write prescriptions by promising to share the revenue with them.	The physicians and two pharmacies agreed to pay $10 million to resolve the allegations. See 25 *BNA's Health Law Reporter* 223 (Feb. 18, 2016).
United States ex rel. Deane v. Dynasplint Health Sys., Inc., No. 10-cv-2085 (E.D. La. settlement agreement announced Dec. 18, 2015).	A splint supplier and its founder knowingly mischarged Medicare for splints used by patients in skilled nursing facilities by misrepresenting that patients were in their homes or other places that were not SNF's to circumvent the bundled payment that the facility receives for providing all of a patient's needs, including such items as splints.	The splint supplier and its founder agreed to pay $10.3 million to resolve the claims. See 244 *BNA's Health Care Daily Report* (Dec. 21, 2015).
United States ex rel. Porter v. Ventage Pharm. LLC, No. 13-CIV-1506 (S.D.N.Y. settlement agreement announced Dec. 16, 2015).	A drug manufacturer, its parent company and seven subsidiaries manufactured and sold tablets between 2007 and 2013 that contained less than half of the indicated amount of fluoride listed on the label.	The manufacturer, its parent company and subsidiaries agreed to pay $39,000,000 to resolve the claims. See 243 *BNA's Health Care Daily Report* (Dec. 18, 2015).
United States ex rel. Nichols v. Sleep Med., No. 3:12-CV-1080-J-25TEM (M.D. Fla. settlement agreement announced Sept. 9, 2014).	The Sleep Medicine Center and two doctors submitted claims for studies and testing that were not medically necessary, were not conducted by appropriately licensed individuals, or were not actually performed at all.	The facility agreed to pay $200,000 to resolve the claims and both the facility and one doctor agreed to be excluded from participation in the federal healthcare programs for eight years. The other doctor agreed to pay nearly $100,000 to resolve the claims. See 177 *BNA's Health Care Daily Report* (Sept. 12, 2014).
United States ex rel. Cederoth v. CRC Health Corp., No. 3:11-cv-897 (M.D. Tenn. settlement announced Apr. 16, 2014).	A drug abuse treatment facility provided substandard services, exceeded its licensed capacity, billed for services not rendered and caused third parties to bill Medicaid for prescription drugs that should have been provided under patients' per diems, among other allegations.	The facility agreed to pay $9.25 million to settle the allegations. See 18 *BNA's Health Care Fraud Rep.* 377 (Apr. 30, 2014).

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Settlement	Alleged Misconduct	Resolution and Penalties
United States ex rel. Turner v. Hope Cancer Inst., No. 2:12-cv-2122 (D. Kan. settlement Apr. 14, 2014).	The owner of a cancer treatment center instructed employees to bill for a predetermined amount of the drugs at certain dosage levels, when lower dosages of the drugs were actually provided to beneficiaries. As a result of these instructions, the center submitted inflated claims to federal healthcare programs for drugs that weren't actually provided to patients over the course of four years.	The center agreed to pay $2.9 million to resolve the allegations. The owner and the center agreed to be excluded for 10 years from participation in Medicare, Medicaid and other federal health-care programs. See 18 *BNA's Health Care Fraud Rep.* 378 (Apr. 30, 2014).
United States ex rel. Angel v. Alliance Rehabilitation LLC, No. 10-cv-2124 (D.D.C. settlement Apr. 10, 2014).	Two physical therapy clinic operators falsely billed Medicare and TRICARE over the course of five years for physical therapy services that were not provided or supervised by the physical therapist listed on the claim. The false claims from the two companies were submitted through a consolidated billing office.	The companies agreed to pay $2.8 million to settle the allegations. The companies and their two owners entered into a five-year corporate integrity agreement (CIA) with the OIG. See 23 *BNA's Health Law Reporter* 545 (Apr. 17, 2014).
United States ex rel. Gonzalez v. Mego, No. 7:07-cv-00241 (S.D. Tex. final judgment Mar. 21, 2014).	Two physicians and their cardiology clinic engaged in a "pattern and practice" of billing Medicare for medical tests and physical examinations performed by unqualified personnel. The cardiologists failed to maintain patient records as required by law, billed Medicare for nuclear tests and physical exams that fell well below the recognized standard of care and filed claims for medically unnecessary nuclear stress tests, coronary angiographies, echocardiograms and carotid Doppler studies.	The cardiologists agreed to pay $3.9 million to resolve the allegations and entered into a three-year integrity agreement with the OIG. See 57 *Health Care Daily Report* (Mar. 25, 2014).
Dr. Steven Chun and Sarasota Pain Associates (M.D. Fla. Feb. 25, 2014).	A physician and his clinic billed Medicare for office visits at the highest levels possible over the course of five years, falsely claiming to have conducted comprehensive examinations of patients with complex problems. Those patients visited the clinic for scheduled procedures for which the physician was paid. The physician also billed and was paid by Medicare for examinations that he did not in fact perform.	The physician agreed to pay $750,000 to resolve the allegations and agreed to a three-year Integrity Agreement with the OIG.

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Settlement	Alleged Misconduct	Resolution and Penalties
United States ex rel. Lovell v. Sharma, No. 8:12-cv-133 (M.D. Fla. order of dismissal Jan. 3, 2014).	A surgeon instructed his office manager to perform varicose vein injections when he was not present at his vein clinic. The office manager was not credentialed in vascular technology, so billing Medicare for reimbursement for the procedures she performed was prohibited. The surgeon also illegally billed Medicare for vascular procedures that required a certain probe to insert the needle or hard copy imaging, at times when they were not used, fraudulently billed Medicare for weight loss visits when he was not physically present, and billed for more extensive procedures than were provided to such patients.	The surgeon agreed to pay $400,000 to resolve the allegations. See 18 *BNA's Health Care Fraud Rep.* 77, (Jan. 22, 2014).
Hafeez Kahn, M.D. (D. R.I. Oct. 4, 2013.)	A physician and two corporations he owned billed Medicare and Medicaid for services not rendered, overbilled for services and unbundled certain CPT codes. The fraudulent billings totaled around $600,000.	The physician agreed to pay $1.2 million to settle the allegations.
United States ex rel. Koch v. Gulf Region Radiation Oncology Ctr., Inc., No. 3:12-cv-504 (N.D. Fla. notice of settlement Sept. 13, 2013).	Radiation oncology providers regularly billed the federal health care programs for oncology services that were not supervised by a physician, as required for reimbursement by those programs. The providers also billed for services not rendered and double-billed and upcoded for other treatments.	The providers agreed to pay $3.5 million to settle the allegations, and entered into integrity agreements with the OIG that involve internal and external oversight.
U.S. v. Rao (W.D. N.C., April 18, 2013).	The owner and chief neurologist at a neurology practice did not directly supervise the administration of intravenous immune globulin (IVIG) therapy, as required under Medicare. He illegally submitted claims for reimbursement from Medicare from October 2003 until May 2006 for such improperly administered treatments.	The neurologist agreed to pay Medicare $2 million, plus interest, in addition to up to $500,000 from sales of his real estate holdings, to settle the allegations.
United States ex rel. West v. Maxim Healthcare Services Inc., D.N.J., No. 04-cv-4906, settlement 9/12/11; *United States v. Maxim Healthcare Services Inc.*, D.N.J., No. 11-cr-6107.	Between 1998 and 2009, a New Jersey skilled nursing facility, one of the country's largest home health care agencies, was alleged to have filed false claims with state Medicaid programs and Veteran's Affairs for services that were not provided, not sufficiently documented to show that they were provided, or were delivered from unlicensed offices.	To resolve the allegations under the False Claims Act the company agreed to pay $121 million plus interest over 8 years and enter a Corporate Integrity Agreement. In addition, the company paid $20 million in criminal fines and entered into a deferred prosecution agreement. *Home Care Provider Pays $150 Million To Resolve Federal Health Fraud Case*, 15 *BNA's Health Fraud Rep.* 734 (Sept. 21, 2011).

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Settlement	Alleged Misconduct	Resolution and Penalties
Kaiser Foundation Health Plan (N.D. Ca., Dec. 3, 2009).	Three related entities self-reported that they had submitted claims to Medicare and Medicaid for services not provided as claimed. Services were reported as having been provided by teaching physicians when in fact the services were provided by resident physicians without the required supervision of teaching physicians.	The entities entered into a settlement agreement with the OIG and the State of California, agreeing to pay the state and federal governments $3.7 million to resolve the allegations that they submitted false claims to Medicare and Medicaid for services not provided as claimed.
Temple Health Services LLC (D. Conn., Jan. 26, 2009).	A medical clinic billed Medicare for physical therapy services and physician's services that were not medically necessary or were not provided as billed. Cardiologists would refer Medicare patients with certain cardiac conditions to the clinic for cardiac rehabilitation. However, almost every time a Medicare patient went to the clinic for those services, it also would bill Medicare for physical therapy services and a physician's office visit, in addition to billing Medicare for the cardiac rehabilitation services.	The clinic entered into a settlement agreement with the OIG and agreed to pay double damages of $284,398 in order to reimburse the Medicare program.
United States ex rel. Vrabel v. Tomball Regional Hospital, No. CV-05-0959 (S.D. Tex., agreement announced Aug. 24, 2007).	A whistleblower lawsuit alleging the hospital billed Medicare and Medicaid for hyperbaric oxygen (HBO) therapy in situations where patients' conditions did not allow payment. The complaint further alleged the hospital and doctor billed and received payments for such therapy although it was never rendered to patients and with documentation that failed to support the diagnosis code billed.	The hospital and physician paid more than $800,000 to settle the alleged violations of the federal False Claims Act and the Texas Medicaid Fraud Prevention Act damages. They paid $796,422 for the alleged Medicare violations and $19,658 for the alleged Medicaid violations. The hospital also entered into a five-year corporate integrity agreementwith the OIG.
United States v. Eckerd Corp., No. 95-2030-CIV-T-17C (M.D. Fla. agreement concluded May 24, 2002).	The pharmacy company filed false Medicaid reimbursement claims for partially filled prescriptions, "shorting" Medicaid customers by partially filling prescriptions and then billing the program and other federal government health programs for the full amount of the medications.	The company agreed to pay $9 million to the federal government and 18 states to settle the civil charges.

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Court Rulings

Facts	Outcome
Between 2008 and 2014, a doctor submitted bills to Medicare for nerve blocking injections that were never provided and conspired with the owner of a medical billing company to circumvent a fraud investigation into his billing practices by creating sham medical practices.	After a jury trial, the doctor was sentenced to 15 years in prison and ordered to pay nearly $9.2 million in restitution. *United States v. Trotter*, No. 14-20273 (E.D. Mich., sentencing Nov. 7, 2017).

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Facts	Outcome
Between 2007 and 2013, the owner of six medical clinics paid cash kickbacks to elderly, low-income patients in exchange for the use of their names to bill Medicare and Medicaid for services and equipment never provided. The owner also used a medical supply company that he partly owned and a medical transportation company to submit bills for medically unnecessary durable medical equipment and ambulance transfers.	The owner pleaded guilty and was sentenced to 10 years in prison and ordered to forfeit nearly $17 million, including 22 pieces of real estate he had already given up. *United States v. Burman*, No. 1:16-cr-00190 (S.D.N.Y., sentencing May 10, 2017). See 91 *Health Care Daily Report* (May 12, 2017).
Between January 2008 and October 2014, a podiatrist submitted false claims to Medicare for podiatric procedures that were not medically necessary or not performed at all and administered painful, medically unnecessary injections for the sole purpose of submitting claims for the procedures to the patients' insurance providers to create the appearance of legitimacy for prescribing opioids to the patients.	The podiatrist pleaded guilty and was sentenced to eight years in prison and ordered to serve three years of supervised release and pay $4,960,295 in restitution. *United States v. Monaco*, No. 2:16-cr-00255-JS (E.D. Pa., sentencing Feb. 7, 2017). See 21 *Health Care Fraud Report* 132 (Feb. 15, 2017).
A neurosurgeon who owned and operated a physician practice group submitted claims to Medicare, Medicaid and various private insurers for spinal fusion surgeries that were never performed, and in some instances, when he did operate on patients, he falsified records by stating that he had performed different services than were actually provided. In addition to submitting false claims, the surgeon was an investor in a medical device company and used more of the company's devices than were medically necessary for his patients in order to generate revenue for the company, which in some cases resulted in serious bodily injury to the patients.	The physician was convicted and sentenced to 235 months in prison. *United States v. Sabit*, No. 14-cr-20779 (E.D. Mich., sentencing Jan. 9, 2017). See 07 *Health Care Daily Report* (Jan. 11, 2017).
An owner of a medical equipment supply company paid patient recruiters for names and billing information of Medicare beneficiaries and used the information to cause the company to submit false and fraudulent claims to Medicare for power wheelchairs and various braces that were medically unnecessary or were never received by the beneficiaries.	The owner was convicted and sentenced to 80 months in prison and ordered to pay $2,004,391.63 in restitution. *U.S. v. Brown et al.*, No. 2:13-cr-00243 (E.D. La., sentencing Aug. 10, 2016).
From May 2013 through July 2013, the owner of a durable medical equipment (DME) company submitted roughly $2.6 million in false and fraudulent claims to Medicare requesting reimbursement for DME that was not prescribed by doctors or not provided to beneficiaries.	The owner pleaded guilty and was sentenced to 37 months in prison and ordered to pay $918,402 in restitution and forfeit the same amount. *United States v. Rodriguez*, No. 8:13-cr-00372 (M.D. Fla., sentencing June 13, 2016). See 115 *Health Care Daily Report* (June 15, 2016).
Husband and wife owners of a home health care agency were involved in an $80 million Medicaid fraud scheme where the wife, whose nursing license was revoked in 1999 and was excluded from participation in Medicare and Medicaid as a result, subsequently concealed her identify and forged documents to apply for a Medicaid provider number for the agency. From August 2009 through February 2014, they billed for personal home health aide services that were not provided and created false time sheets, patient files and employment files. The agency generated increasing payment amounts going from roughly $1.35 million in 2009 to $27.6 million in 2013.	The owners were convicted, and the wife was sentenced to 10 years in prison and the husband to seven years. They were ordered to forfeit over $11 million seized from 76 bank accounts; their residence; $73,000 in cash, and five luxury vehicles valued at more than $400,000. The owners were also ordered to forfeit approximately $40 million and pay $80.6 million in restitution. *United States v. Bikundi*, No. 1:14-cr-00030 (sentencing June 1, 2016).
A physician who specialized in interventional pain management owned and operated a pain clinic with his wife where from January 2011 through May 2014 they billed multiple federal health benefit programs for procedures that either provided higher reimbursement amounts than the procedures they actually performed or were never performed.	The physician was convicted by a jury and sentenced to 111 months in prison followed by three years of supervised release and ordered to forfeit and pay over $3.1 million in restitution. *United States v. Ajrway*, No. 14-cr-00316-DKC, (sentencing Apr. 11, 2016). See 71 *Health Care Daily Report* (D. Md., Apr. 13, 2016).

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Facts	Outcome
A psychiatrist submitted approximately $158 million in false claims to Medicare and falsified medical records to support the claims for partial hospitalization program services where beneficiaries rarely saw a psychiatrist or did not receive services at all.	The psychiatrist was convicted by a jury and sentenced to 144 months in prison and ordered to pay over $6.3 million in restitution. *United States v. Iglehart*, No. 4:13-cr-00746, (sentencing Apr. 1, 2016). See 65 *Health Care Daily Report* (S.D. Tex., Apr. 5, 2016).
The president of a transportation company used the company to arrange kickback payments to recruiters in return for the referral of patients to several mental health clinics, that in turn, submitted approximately $70 million in claims to Medicare for services that were not medically necessary or not provided.	The businessman was convicted by a jury and sentenced to 60 months in prison and ordered to pay $26,808,841 in restitution. *United States v. Borges*, No. 1:15-cr-20383, (S.D. Fla., sentencing Mar. 25, 2016). See 60 *Health Care Daily Report* (Mar. 29, 2016).
From 2010 to 2015, a businessman associated with outpatient behavioral health and health service providers recruited hundreds of Medicaid beneficiaries to receive alleged services and billed Medicaid for services that were never actually provided. He also converted approximately $1 million of the fraudulent proceeds into an alleged loan payment to a third party; however, no documentation was recovered to support the existence of a loan. The loan proceeds were then transferred back to him in cash. After an initial investigation revealed fraudulent medical records, the businessman's company was suspended from the Medicaid program. He then used names of other providers to continue submitting fraudulent claims.	The businessman pleaded guilty and was sentenced to 240 months in prison and ordered to pay $5,9 million in restitution. *United States v. Speller*, No. 4:15-cr-46, (E.D.N.C., sentencing March 21, 2016). See 57 *Health Care Daily Report* (Mar. 24, 2016).
From June 2010 through May 2014, an audiologist, along with her co-conspirators, used forged and falsified documents to enroll patients in the Medicare program and billed Medicare for services that were not rendered by physicians. She also paid illegal kickbacks in exchange for beneficiaries' information used in the fraud scheme.	The audiologist was convicted by a jury and sentenced to 94 months in prison and ordered to pay $2,512,460 in restitution, joint and several. *United States v. Lovelace*, No. 8:14-cr-00164 (M.D. Fla., sentencing Mar. 21, 2016). See 55 *Health Care Daily Report* (Mar. 22, 2016).
From 2005 through June 2014, a physician billed Medicare, Medicaid and private payers for office visits that never happened and wrote prescriptions and authorized refills without ever seeing patients in person. The physician admitted that he altered medical records to make it appear as if patients visited his office when they did not.	The physician pleaded guilty and was sentenced to 37 months in prison and 3 years of supervised released and ordered to forfeit $280,000. *United States v. Ades*, (D.N.J., sentencing Mar. 14, 2016).
A physician pre-signed thousands of prescriptions for anit-psychotic medications, which were then billed to Medicare and MediCal programs in excess of $20 million.	The physician was convicted by a jury and was sentenced to 9 years in prison. *United States v. Johnson*, No. 2:11-cr-01075-SJO (C.D. Cal., sentencing Jan. 6, 2016). See 05 *Health Care Daily Report* (Jan. 8, 2016).
From 2009 to 2014, a psychiatrist submitted claims to Medicare, Medicaid and other health insurance carriers for services rendered to nursing home residents, clients of mental health and mental retardation organizations and foster care children. The services were either not rendered at all or not rendered in the manner for which they were billed.	The psychiatrist pleaded guilty and was sentenced to 71 months in prison and ordered to pay $1,832,869 in restitution and forfeit $2,000,000. *United States v. Gross*, No. 6:14-CR-038-S (N.D. Tex., sentencing Dec. 17, 2015).
From 2008 to 2012, a physician employed unlicensed individuals through his visiting physician practice who purported to provide home visits and other services to beneficiaries and prepared medical documentation that the physician and other licensed physicians signed as if they had performed the services when no licensed physicians had treated the beneficiaries.	The physician pleaded guilty and was sentenced to 72 months in prison and ordered to pay $2,073,108 in restitution. *United States v. Elhorr*, No. 13-20158 (E.D. Mich., sentencing Nov. 19, 2015). See 224 *Health Care Daily Report* (Nov. 20, 2015).

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Facts	Outcome
From October 2012 to September 2013, the owner of a pharmacy submitted claims to Medicare for prescription drugs that were not prescribed, not medically necessary, and not provided to beneficiaries. The owner also used beneficiaries' and physicians' identification numbers on the claims without their consent.	The owner pleaded guilty and was sentenced to 42 months in prison and ordered to pay $1,583,976 in restitution. *United States v. Esponda*, No. 1:15-cr-20439 (S.D. Fla., Nov. 13, 2015).
From February 2012 to September 2014, the owners of a healthcare clinic billed Medicare for services that were never provided and for medications that were not prescribed or administered.	The owners pleaded guilty and were sentenced to five years in prison and one year and one day in prison, respectively, and were ordered to pay $1,520,850 in restitution and forfeit $1,520,850. *United States v. Delgado*, No. 6:14-cr-00260 (M.D. Fla., sentencing Sept. 29, 2015). See 190 *Health Care Daily Report* (Oct. 1, 2015).
The primary medical biller of a home visiting physician practice group routinely billed Medicare for overseeing patient care plans when the physicians rarely provided the service and billed Medicare for services that were never provided, including services rendered to deceased patients and provided by physicians that were no longer employed by the group.	After a jury trial, the medical biller was sentenced to 45 months in prison and ordered to pay $1 million in restitution. *United States v. Brown*, No. 1:13-cr-00854 (N.D. Ill., sentencing Sept. 18, 2015). See 184 *Health Care Daily Report* (Sept. 23, 2015).
An administrator of a home visiting physician practice group billed Medicare for patient care plan oversight when the physicians rarely provided the service.	After a jury trial, the administrator was sentenced to 87 months in prison. *United States v. Brown*, No. 1:13-cr-00854 (N.D. Ill., sentencing Sept. 4, 2015). See 174 *Health Care Daily Report* (Sept. 9, 2015).
An owner of multiple HIV/AIDS clinics billed Medicare for treatments that were administered at highly diluted doses or never administered at all and were often unnecessary. The owner recruited Medicare beneficiaries to come to the clinic for unnecessary treatments and paid them kickbacks, and also paid patients for each new patient they recruited.	The owner pleaded guilty and was sentenced to 87 months in prison and ordered to pay $3.5 million in restitution and forfeit $31.2 million, including $14 million in seized assets. *United States v. Huachillo*, No. 1:13-cr-00995 (S.D.N.Y., sentencing Aug. 25, 2015). See 166 *Health Care Daily Report* (Aug. 27, 2015).
An owner of a pharmacy paid kickbacks to Medicare beneficiaries over a 7-year period to induce them to submit their prescriptions to the pharmacy and submitted fraudulent claims to Medicare Part D plan sponsors for prescriptions that were not actually filled.	The owner pleaded guilty and was sentenced to 18 months in prison and ordered to pay $644,060 in restitution and $50,000 as a monetary penalty. *United States v. Javaherian*, No. 2:15-cr-00045-SVW (C.D. Cal., sentencing Aug. 3, 2015). See 150 *Health Care Daily Report* (Aug. 5, 2015).
An owner of two home health agencies paid kickbacks to patient recruiters in exchange for information on Medicare beneficiaries and created fake patient files to mislead a Medicare auditor. He submitted claims to Medicare for services that were not medically necessary or not provided at all.	The owner pleaded and was sentenced to 80 months in prison and ordered to pay $14.1 million in restitution. *United States v. Sharma*, No. 12-20272 (E.D. Mich., sentencing July 23, 2015). See 143 *Health Care Daily Report* (July 27, 2015).
The president of a hospital, his son and a co-conspirator engaged in a $158 million Medicare fraud scheme from 2005 through June 2012 where they submitted fraudulent claims for mental health services when patients did not qualify for nor need the services. They also paid kickbacks to patient recruiters and owners and operators of group care homes in exchange for referrals of Medicare beneficiaries to the hospital for partial hospitalization program services.	After a jury trial, the president, his son and the co-conspirator were sentenced to 45 years, 20 years and 12 years in prison and ordered to pay restitution in the amount of $46,753,180, $7,518,480 and $46,255,893, respectively. *United States v. Gibson*, No. 4:12-cr-600 (S.D. Tex. sentencing June 9, 2015). See 19 *Health Care Fraud Report* 501 (June 24, 2015).
A physician at a psychiatric hospital falsified medical records for over 400 patients certifying that they qualified for and received outpatient services when they did not. He also certified that he had provided services to each of them, when in fact he never saw nor treated any of them.	The physician was sentenced to 60 months in prison and ordered to pay $2.9 million in restitution. *United States v. Kaplowitz*, No. 1:14-cr-20323 (S.D. Fla. sentencing Apr. 30, 2015). See 84 *Health Care Daily Report* (May 1, 2015).

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Facts	Outcome
The operator of an adult day care center and two owners of home health agencies participated in a Medicare scheme where the operator sold private medical information of patients to the two owners, which was then used to submit fraudulent claims to Medicare. The owners paid kickbacks to the operator and others in exchange for referrals, and both the owners and operator submitted claims to Medicare for services that were never provided. Further, the owner billed for services purportedly provided to patients who were already deceased.	The operator was sentenced to five years in prison and ordered to pay $2,431,018 in restitution while the two owners were sentenced to 10 years in prison and four years in prison, respectively, and ordered to pay $8,389,541 and $589,516 in restitution, respectively. *United States v. Sharma*, No. 12-20272 (E.D. Mich. sentencing Apr. 21, 2015). See 78 *Health Care Daily Report* (Apr. 24, 2015).
The owner of a psychotherapy clinic used Medicare information of hundreds of beneficiaries without their consent to submit claims for services that were not actually provided. He also used social workers' personal information without their consent to obtain Medicare provider numbers and submit claims for services purportedly provided by those same social workers.	The owner was sentenced to 87 months in prison and ordered to pay $1,453,064.59 in restitution. *United States v. Funderburg*, No. 2:11-cr-20494 (E.D. Mich. sentencing Feb. 27, 2015). See 41 *Health Care Daily Report* (Mar. 3, 2015).
An owner and operator of a psychotherapy clinic and his employee participated in a Medicare scheme where the owner, a licensed physician, represented that he provided psychotherapy to patients, when in fact, the sessions were conducted by the employee, a graduate student. Both knew the services were only reimbursable when performed by an enrolled Medicare provider. The owner did not participate in nor supervise any of the sessions. Additionally, they billed Medicare for more patient visits than were actually conducted and for purported sessions with patients who were deceased at the time.	The owner was sentenced to 88 months in prison and the employee was sentenced to 70 months. *United States v. Ferrell*, No. 11-cr-595 (N.D. Ill. sentencing Feb. 23, 2015).
An owner and operator of a home health care agency that purported to provide home health and therapy services participated in a Medicare fraud scheme where he billed Medicare for extensive physical therapy and home health services that were not medically necessary or not performed at all. He falsified medical documents and planned, organized and oversaw the submission of false claims to Medicare. He also recruited patients for home health agencies in exchange for kickbacks.	The owner was sentenced to 10 years in prison and ordered to pay $2,163,057 in restitution and to forfeit $9,061,867, which relates to the proceeds traceable to his criminal conduct. *United States v. Fernandez*, No. 1:14-cr-20712 (S.D. Fla. sentencing Feb. 3, 2015). See 24 *Health Care Daily Report* (Feb. 5, 2015).
Four Florida residents participated in a $6.2 million Medicare fraud scheme. All four acted as patient recruiters for a home health agency that purported to provide home health and therapy services. They solicited and received kickbacks and bribes from other co-conspirators in exchange for recruiting beneficiaries who either did not need or did not receive services at all. Three of the defendants acted as managers, supervisors, owners, and operators. They coordinated and oversaw the submission of fraudulent claims, and they falsified medical documents to make it appear that the beneficiaries qualified for and received services that were, in fact, not medically necessary or provided.	Two of the defendants were sentenced to 120 months in prison and the other two were sentenced to 97 months and 24 months in prison, respectively. They were ordered to pay $204,526.05, $1,438,186, $2,972,570, and $4,938,432, respectively, in restitution. *United States v. Fernandez*, No. 1:14-cr-20712 (S.D. Fla.. sentencing Jan. 29, 2015). See 21 *Health Care Daily Report* (Feb. 2, 2015).
A physician referred Medicare beneficiaries for home health care services that were not medically necessary and never provided. She falsified medical documents and certified beneficiaries as homebound when, in fact, she had never examined nor even met the beneficiaries, and they were not homebound.	The physician was sentenced to 15 months in prison and ordered to pay $1,343,261.61 in restitution. *United States v. Hakim*, No. 13-20347 (E.D. Mich. sentencing Jan. 14, 2015). See 19 *BNA's Health Care Fraud Rep.* (Jan. 21, 2015).

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Facts	Outcome
Two physician owners of a community mental health clinic and a group home owner participated in a $97 million Medicare fraud scheme. The physicians billed Medicare for partial hospitalization program services for beneficiaries that did not qualify for or need the services. The physicians signed admission documents and progress notes certifying that patients qualified for the services, and also paid kickbacks to the group home operator and other operators and patient recruiters in exchange for delivering patients to the clinic. In some cases, patients received a portion of those kickbacks.	The two physicians were sentenced to 120 months and 148 months in prison, respectively, and ordered to pay a total of $8,058,612.39 in restitution. The group owner was sentenced to 54 months in prison and ordered to pay $1,885,667.41 in restitution. *United States v. Sanjar*, No. 4:11-cr-00861 (S.D. Tex. sentencing Jan. 12, 2015). See 9 *Health Care Daily Report* (Jan. 15, 2015).
The owner of a purported non-profit Medicaid-approved company providing mental health and mentoring services submitted false claims for reimbursement for mental health services that were either provided by unlicensed, non-Medicaid approved individuals or were never provided at all. The claims used the Medicaid provider numbers of at least three licensed clinicians, who neither provided the claimed services nor knew that the owner was submitting the false claims. The owner also obtained Medicaid beneficiary information from other organizations and used that information to submit claims for made-up services.	The owner was sentenced to 30 months in prison and ordered to serve three years under court supervision and pay $3,153,074 in restitution. *United States v. Robinson*, No. 3:13-cr-318 (W.D.N.C. sentencing Jan. 8, 2015).
An acupuncturist and clinic owner filed fraudulent claims with Medicare and Blue Cross Blue Shield for acupuncture, massage therapy and other medical services. Medicare does not reimburse for acupuncture services, and the massage therapy services were not provided by licensed physical therapists or physical therapy assistants.	The acupuncturist and clinic owner was sentenced to two years and nine months in prison and three years of supervised release. He was ordered to pay $1.2 million in restitution. *United States v. Park*, No. 1:13-cr-00490 (N.D. Ga. sentencing Dec. 12, 2014). See 248 *Health Care Daily Report* 340 (Dec. 29, 2014).
The operator of after-school and summer child care programs and a patient recruiter for the programs engaged in Medicaid fraud schemes involving false claims for sham mental and behavioral health services, recruiting Medicaid recipients by promising them the programs free of charge, and then using the recipient numbers to bill Medicaid for mental and behavioral health services that were never provided. Because the operator was not licensed to provide such services, she enlisted certain Medicaid-approved providers to submit claims and share in the fraudulently obtained reimbursement, and at other times she used stolen provider numbers. The recruiter worked in the operator's fraud scheme and later created her own company to engage in a separate but similar fraud scheme, stealing provider numbers and using them to bill for services that were not provided and redirecting Medicaid payments away from licensed providers' bank accounts.	The operator pleaded guilty and was sentenced to 111 months in prison and ordered to pay about $7 million in restitution to Medicaid and about $573,000 to the Internal Revenue Service. *United States v. Brewton*, No. 3:12-cr-399 (W.D.N.C. sentencing Apr. 9, 2014). The patient recruiter pleaded guilty to health care fraud, identity theft, and money laundering, and was sentenced to 102 months in prison and ordered to pay more than $2.5 million in restitution. *United States v. Cannon*, No. 3:13-cr-95 (W.D.N.C. sentencing Apr. 8, 2014). See 18 *BNA's Health Care Fraud Rep.* 340 (Apr. 16, 2014).
The "straw owner" of a physical therapy clinic posed as the owner of the clinic during part of 2008, following a sham sale by the clinic's actual owners. During that time, the clinic filed approximately $1.6 million of Medicare claims for physical therapy services that were not provided, and Medicare paid $446,738.	The "straw owner" was sentenced to 30 months in prison followed by three years of supervised release and ordered to pay restitution of approximately $447,000. *United States v. Duluc*, No. 8:12-cr-00150 (M.D. Fla. sentencing order filed Mar. 18, 2014). See 54 *Health Care Daily Report* (Mar. 20, 2014).

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Facts	Outcome
A psychiatrist submitted $4 million in Medicare claims over seven years for home visits that did not occur. Some claims were for home visits at New York locations during times when he was actually in China, and 55 claims were for home visits for Medicare beneficiaries who were in the hospital on the date the visit allegedly occurred. The psychiatrist's average patient visits per day increased from 7.25 patients in 2006 to 15.66 patients in 2010, in addition to his full-time salaried position at a VA hospital.	The psychiatrist was sentenced to 18 months in prison, to forfeit $1.2 million, and ordered to serve three years of supervised release. *United States v. Presman,* No. 13-cr-576 (E.D.N.Y. sentencing Mar. 13, 2014). See 18 *BNA's Health Care Fraud Rep.* 238 (Mar. 19, 2014).
The owner of a counseling provider filed more than $200,000 in false claims over three years, including claims for services that were not provided and/or not documented. Some services were billed as individual therapy sessions when they actually took place in group therapy sessions. Some claims were for services provided by the same employee to different patients during overlapping times.	The owner was sentenced to 10 years in prison. *State v. Pinkard,* No. 2013CR01520-06 (Ga. Supr. Ct. sentencing order filed Feb. 28, 2014). See 18 *BNA's Health Care Fraud Rep.* 243 (Mar. 19, 2014).
The owner of two adult day care centers lured narcotics users to come to the centers, telling them they could see a doctor who would prescribe them the drugs they wanted if they signed up for a psychotherapy program. Other personnel used the drug seekers' Medicare information and signatures to bill Medicare for psychotherapy services that were never provided, and fabricated patient records and psychotherapy sign-in sheets. The centers submitted approximately $3.28 million in false Medicare claims over two years.	The owner was sentenced to eight years in prison, ordered to pay $988,529 in restitution and required to serve three years of supervised release following his prison term. *United States v. English,* No. 2:12-cr-20269-VAR-LJM (E.D. Mich. sentencing Feb. 27, 2014). See 41 *BNA's Health Care Daily Report* (Mar. 3, 2014).
The former owner of a medical clinic continued to bill Medicare after she sold the clinic to another health care provider in 2007. The fraudulent billing garnered more than $400,000 from Medicare for services never rendered. The former owner also claimed the services for which she billed Medicare were performed by a physician who no longer worked at the clinic.	The former owner was sentenced to two years in prison and ordered to pay $411,000 in restitution. *United States v. Nesmith*, No. 2:13-cr-615 (D.S.C. sentencing Feb. 21, 2014). See 37 *BNA's Health Care Daily Report* (Feb. 25, 2014).
A dental office employee and her husband recruited individuals who provided their insurance policy numbers. The couple then submitted false claims to Blue Cross Blue Shield of South Carolina using those policy numbers, claiming that the individuals had been seen by her dentist-employer when they had not. The conspirators split the proceeds from their fraud scheme with the individuals who had provided their policy numbers. The couple submitted about $800,000 in such fraudulent claims to the insurance plan over two years, and received about $368,000 in reimbursement.	The employee was sentenced to 51 months in prison and ordered to pay $126,000 in restitution. Seven other conspirators pleaded guilty for their roles in the scheme. *United States v. Robinson-Taylor*, No. 3:13-cr-652 (D.S.C. sentencing Jan. 27, 2014). See 18 *BNA's Health Care Daily Report* (Jan. 28, 2014).
A former therapist and co-conspirators at a mental health clinic submitted fraudulent claims purportedly related to a partial hospitalization program (PHP), an intensive treatment for severe mental illness. As part of the scheme, the therapist and others paid kickbacks to patient recruiters who referred Medicare beneficiaries to the clinic who were not eligible for PHP. The therapist performed sham therapy sessions for patients he knew were ineligible for PHP and billed Medicare for partial sessions or for sessions that never occurred. He also created false therapy notes and other supporting documentation as part of the scheme.	The therapist was sentenced to 10 years in prison and ordered to pay more than $11 million in restitution, jointly and severally with his co-conspirators. *United States v. Kalfus,* No. 1:13-cr-20062 (S.D. Fla. sentencing Nov. 6, 2013).

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Facts	Outcome
A medical clinic served as a Medicare billing mill, paying cash kickbacks to obtain the names of beneficiaries to bill for more than $77 million in services that were medically unnecessary or never provided. The medical director authorized his co-conspirators at the clinic to use his Medicare billing number to fraudulently bill for more than $20 million in medical procedures and services that were never performed. He received more than $500,000 for his role in the scheme.	The medical director was sentenced to serve 151 months in prison, ordered to forfeit $511,000 and held responsible for nearly $51 million in restitution. His medical license was revoked, and the judge barred him from employment with any federally funded medical program during three years of supervised release to follow his prison term. The clinic's owner was sentenced to 15 years in prison, followed by three years of supervised release with a concurrent exclusion from federal healthcare programs, and ordered to forfeit $36.2 million and pay $50.9 million in restitution. A clinic employee was sentenced to eight years in prison, ordered to forfeit $446,655 and to pay $10 million in restitution, and was excluded from all federal health programs. *United States v. Drivas,* No. 10-cr-771 (E.D.N.Y. sentencing Sept. 16, 2013).
A psychiatrist owner of two Texas pain management clinics and individuals employed at his clinics performed prolotherapy on patients, a nonsurgical treatment for chronic pain that was not reimbursed by federal health care programs, and billed the federal programs for facet joint injections. The clinics submitted fraudulent claims for peripheral nerve injections that were not given to patients, and for office visits as Level Four visits that typically involve 25 minutes of face-to-face time between the physician and patient. The owner also filed fraudulent claims for evaluation management, representing that he treated patients for separately identifiable problems. The fraudulent claims totaled more than $44 million.	The owner was convicted by a jury of health care fraud, conspiracy to commit health care fraud, making false statements related to health care matters and money laundering. He was sentenced to 25 years in prison and three years of supervised release. He was ordered to pay $13.3 million in restitution and forfeit $1.7 million in cash, in addition to a $9.7 million monetary judgment and an order to forfeit two residences and five vehicles. The sentence was upheld on appeal by the Fifth Circuit. *United States v. Valdez,* No. 12-50027 (5th Cir., Aug. 12, 2013). See 17 *BNA's Health Care Fraud Rep.* 753 (Aug. 21, 2013).
Husband and wife physicians billed health care providers for injection procedures they did not perform in a decade-long scam. The defendants provided only superficial injections of lidocaine, combined with steroids to temporarily relieve joint and muscle pain, rather than the facet joint injections, paravertebral injections, sacroiliac nerve injections, sciatic nerve injections, and various other nerve block injections for which they billed Medicare, Medicaid, and private insurance companies. The doctors often saw more than 100 patients per day and required certain patients to sign blank progress and procedure notes that were used to generate a "superbill" for insurance companies. The defendants also hired several foreign medical graduates to help add fictitious patient exam info to the blank progress/procedure notes.	The physicians were resentenced to pay $37.7 million in restitution after the appeals court rejected the lower court's $43 million restitution order because the amount exceeded the insurers' actual losses. The husband was sentenced to 15 years in prison, and his wife to eight years. *Babalola v. Sharma*, No. 4:11-cv-4026 (S.D. Tex., resentenced June 3, 2013).

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Facts	Outcome
A Texas nursing services company operator and his co-conspirators fraudulently used the company to pay cash kickbacks to Medicare beneficiaries and patient recruiters, supposedly to provide physical therapy services to Medicare beneficiaries even though it did not employ any licensed or qualified physical therapists, and bill Medicare for physical therapy services that were not rendered. To mask this practice, the company created false and fraudulent patient files to reflect services that were not provided.	After being found guilty of conspiracy, health care fraud, and mail fraud, the physical therapy clinic's owner was sentenced to 27 years and 3 months of incarceration and ordered to pay more than $30.2 million in restitution; its medical director was sentenced to 135 months in prison and ordered to pay $15.6 million in restitution, and an employee was sentenced to 46 months. *United States v. Imo* (S.D. Tex., No. 4:09-cr-00426, sentenced Oct. 28, 2011). See 15 *BNA's Health Care Fraud Rep.* 873 (Nov. 2, 2011). A co-conspirator, a Medicare recruiter, was later sentenced to 37 months in prison, and another co-conspirator, head of the nursing services operator, was sentenced to 12.5 years in prison and ordered to pay more than $19 million in restitution. An eighth co-conspirator was sentenced to 41 months in prison.
A company which purportedly operated partial hospitalization programs (PHPs), a form of intensive treatment for severe mental illness, over an eight-year period paid bribes and kickbacks to owners and operators of assisted living facilities and halfway houses and to patient brokers in exchange for delivering ineligible patients to the facilities. The company owners caused the alteration of patient files and therapist notes for the purpose of making it falsely appear that patients being treated by the company qualified for PHP treatments and that the treatments provided were legitimate PHP treatments. At least one conspirator would "robo-sign" patient files as a supervising therapist without having treated the patients and signed files as though she had been in two places at the same time. In addition, the owners knew physicians were signing patient files without reading them or seeing patients. In some cases, the owners provided the physicians with the files for their signature.	Two co-owners of the company pleaded guilty and were sentenced to 50 years and 35 years in prison, respectively, for orchestrating the $205 million billing scheme. (*United States v. Duran*, S.D. Fla., No. 10-20767-CR-King). The third co-owner was tried and convicted of 24 felony counts and sentenced to 35 years in prison. The three co-owners were ordered to pay more than $87 million in restitution. Several other co-conspirators were sentenced to terms ranging from 18 months to nine years in prison, and ordered to pay restitution totalling more than $72 million. See 15 *BNA's Health Care Fraud Rep.* 996 (Dec. 14, 2011); 16 *BNA's Health Care Fraud Rep.* 866 (Oct. 31, 2012).

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