2023 NHCAA

Awards Program

November 7, 2023

NHCAA

Our Mission *is to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution, and prevention of health care fraud and abuse.*

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NHCAA

John Morris Volunteer Service Award

National Health Care Anti-Fraud Association

Michael J. Cohen, DHSc, JD, PA-C

Each year, the NHCAA John Morris Volunteer Service Award recognizes an individual who has made an exceptional contribution in support of the mission of the National Health Care Anti-Fraud Association.

NHCAA is delighted to name **Dr. Michael J. Cohen** as recipient of the **2023 NHCAA John Morris Volunteer Service Award**.

As a Headquarters Operations Officer with the U.S. Department of Health and Human Services, Office of Inspector General (OIG), Office of Investigations, Dr. Cohen is responsible for pharmaceutical fraud law-enforcement program oversight in Washington, D.C.

The commitment to volunteerism that Dr. Cohen regularly models, particularly on behalf of NHCAA, is remarkable. For well more than a decade, Dr. Cohen has generously shared his knowledge and expertise with the health care anti-fraud community as a subject matter expert. He has served as faculty at a dozen Annual Training Conferences along with scores of other NHCAA webinars, training programs, and events.

Dr. Cohen has co-authored multiple NHCAA Fraud Briefs including the NHCAA COVID-19 Fraud Brief and the Non-FDA Approved Buprenorphine-Naltrexone Pellets Fraud Brief, among others. He has actively engaged with several NHCAA work groups. Most recently, Dr. Cohen was critical to NHCAA's effort in establishing a work group to examine the potential for health care fraud in remote patient monitoring. His presentation to the group on the potential for patient harm was truly insightful. His work with NHCAA's Prescription Drug Fraud Interest Group is also of note.

He can be counted on to consistently engage with his industry peers through NHCAA's monthly Information-Sharing Conference Calls, offering insights and assistance. Dr. Cohen has written submissions for NHCAA's quarterly publication *The Compass* and has been an active and valuable member of the Education and Training Committee for many years.

NHCAA CEO Louis Saccoccio states, "Mike Cohen's generosity of spirit is truly humbling. He represents the very best that our field has to offer and NHCAA is fortunate to have Mike as a partner and friend."

Dr. Cohen has been at OIG headquarters for the past thirteen years. His current work includes identifying schemes and conducting analysis of newly approved pharmaceuticals that are subject to diversion. He has 30 years' experience in clinical health care.

HHS-OIG Deputy Inspector General for Investigations Christian Schrank states, "Mike Cohen is the consummate teammate—his selfless dedication to our collective mission is second to none, it is wonderful to see his efforts to support our partnership recognized."

Prior to his time with the OIG, Dr. Cohen worked for the U.S. Attorney's Office in Miami, Florida in the Healthcare Fraud Division. He received undergraduate degrees in biology and chemistry from the University of Richmond, physician assistant training from George Washington University, a law degree with a specialty in Health Law, and Doctor of Health Sciences from A.T. Still University.

Congratulations to Dr. Michael J. Cohen for being named NHCAA's 2023 recipient of the John Morris Volunteer Service Award.

HISTORY OF THE JOHN MORRIS VOLUNTEER SERVICE AWARD: *This award was established in 2018 to honor the memory of one of NHCAA's most ardent and loyal supporters, John George Morris, Jr. John was a founding member of NHCAA in 1985, who served for many years on the NHCAA Board of Directors, including as Board Chair in 2003. Following his service to the Board, John continued to actively participate in NHCAA committees and activities and unselfishly volunteered his time and expertise to assist with countless NHCAA projects. Even in retirement he served, volunteering as an honorary NHCAA staff member at several Annual Training Conferences. John Morris was a true friend to the Association and his philosophy of service inspired NHCAA to inaugurate a volunteer service award in his honor.*

NHCAA

Excellence in Public Awareness Award

National Health Care Anti-Fraud Association

Law Enforcement Collaboration to Address Sober Home Fraud Schemes Targeting Indigenous Communities

The National Health Care Anti-Fraud Association is proud to recognize the exemplary efforts and remarkable collaboration of the **Federal Bureau of Investigation**, the **Gallup New Mexico Police Department**, and the **Navajo Nation Division of Public Safety** with its **2023 Excellence in Public Awareness Award**.

The Award team represents a coalition of like-minded community partners who worked together to address critical public safety issues. The multi-agency team identified an emerging health care fraud scheme impacting several communities and alerted the public to the danger—most critically, the unhoused Indigenous peoples that the scheme was designed to target. Beyond the important investigative success in identifying and unraveling the complexities of the fraud scheme, this effort also helped reunite missing Indigenous persons with their loved ones.

In 2022 the FBI launched its Missing or Murdered Indigenous Persons Initiative (MMIP), a pilot project aimed at understanding the scope of the missing Indigenous population across New Mexico and the Navajo Nation. Tangentially, it was discovered that a related residential behavioral health facility (RBHF) fraud scheme was developing in Arizona.

The FBI trained law enforcement agencies on conducting comprehensive missing persons investigations, including looking for overlap with criminal activity. Officials located near the Navajo Nation discerned an interrelationship between New Mexico and Arizona regarding the transient nature of missing Indigenous persons, particularly those experiencing homelessness. Reports of abductions relating to a health care fraud scheme began to circulate among community partners.

Police officers from the Gallup Police Department were the first to notify the FBI Albuquerque Field Office of unhoused Indigenous persons disappearing from the streets of Gallup, New Mexico. It was revealed that they were targeted, recruited, and transported to sober living homes in Arizona, where the scheme primarily involved billing for services not rendered, including counseling and substance abuse treatment. In some instances, sober home residents were provided drugs and alcohol and at least one individual sadly died.

The Navajo Nation Division of Public Safety (DPS) issued public warnings about the fraud scheme and made multiple trips to RBHFs in the Phoenix area to search for missing persons and perform welfare and safety checks. The DPS and Gallup PD actively engaged with fraud victims and learned the methods used by sober home recruiters.

The collective efforts of the FBI, Gallup PD, and the Navajo Nation DPS garnered significant media coverage, locally as well as nationally, involved multiple websites, social media campaigns, awareness briefings, published reports, surveys, trainings, face-to-face engagement with Indigenous and homeless communities, and many other public-facing resources.

NHCAA commends the Federal Bureau of Investigation, the Gallup Police Department, and the Navajo Nation Department of Public Safety for their success in raising public awareness of the exploitive nature of health care fraud and how it impacts families and communities.

CONGRATULATIONS TO

FEDERAL BUREAU OF INVESTIGATION
United States Department of Justice

Garrett Canterbury, *Tactical Specialist*
Nicholas Faulkner, *Intelligence Analyst*
Antoinette Ferrari, *Special Agent*
Dominick Margarella, CPA, CFE, *Forensic Accountant*
Donald L. Metzmeier, *Intelligence Analyst*
Megan Mikes, *Intelligence Analyst*
Nicolette Rose, *Intelligence Analyst*
Maria Watson, *Intelligence Analyst*
Carol A. York, *Tactical Specialist*

GALLUP POLICE DEPARTMENT
Criminal Investigations Division

Anthony Seciwa, *Lieutenant*
Andrea Tsosie, *Sergeant*

NAVAJO NATION POLICE DEPARTMENT
Navajo Nation Division of Public Safety

Reycita Jean Billie, *PSAP Supervisor, MMIP Liaison*
Rowland Dash, *Sergeant*
Daryl T. Noon, *Chief of Police*

NHCAA
SIRIS
INVESTIGATION OF THE YEAR
HONORABLE MENTION
National Health Care Anti-Fraud Association

United States of America v. Anita Louise Jackson

Among this year's nominations was a fascinating case from North Carolina that incorporated the use of NHCAA's SIRIS® database. The National Health Care Anti-Fraud Association is happy to recognize the investigation and prosecution teams in the **United States of America v. Anita Louise Jackson** with this year's **SIRIS® Investigation of the Year Award, Honorable Mention**.

Anita Jackson was an ENT doctor who operated Greater Carolina Ear, Nose, and Throat (GCENT), with three offices across Eastern North Carolina. Jackson was the top-biller in the nation for balloon sinuplasty, an in-office procedure to treat chronic sinusitis. Her practice marketed balloon sinuplasty as a "sinus spa," and encouraged patients to come to the office for a "free" sinus spa.

Between 2011 and 2017, Jackson performed 1,555 balloon sinuplasty surgeries on 919 Medicare beneficiary patients, using the FDA-approved Entellus XprESS device. However, rather than use the device just once on one patient, per FDA guidelines, Jackson reused the devices on multiple patients without informing them.

The investigation found that between 2012 and 2017, Jackson acquired, at most, 36 new Entellus devices. During trial, Jackson admitted that she had adequate funds to purchase a new device for each patient but chose not to, putting patients at risk. To justify billing for the unnecessary surgeries to Medicare auditors, medical records were falsified, and patient signatures were forged.

Between 2014 and 2018, she billed Medicare more than $46 million for the procedure, netting in excess of $4.79 million. This billing amount does not include sinuplasty surgeries performed on patients with private health care insurance. Federal investigators enlisted the use of SIRIS® to help identify private insurer victims. It was revealed that Jackson had billed multiple private insurance companies for the procedure as well.

Beneficiary interviews were crucial to the development of this case. In January 2023, Jackson was found guilty by a federal jury on 20 criminal counts, including device adulteration, fraud, conspiracy, and identity theft. She was subsequently sentenced in June 2023 to 25 years in prison. The total restitution ordered was $5.7 million, split amongst Medicare, N.C. Medicaid, TRICARE, private insurances, and patient victims. Additionally, there was a forfeiture order of $4.8 million and a special assessment of $2,000. The total money judgement was $10.5 million.

CONGRATULATIONS TO

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Investigations

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UNITED STATES DEPARTMENT OF JUSTICE

United States Attorney's Office
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Stephanie Wilburn, CPA, *Forensic Auditor*

UNITED STATES DEPARTMENT OF DEFENSE

Office of Inspector General
Defense Criminal Investigative Service

Joseph M. Duracinsky, *Special Agent*

UNITED STATES FOOD AND DRUG ADMINISTRATION

Office of Criminal Investigations

Christine Berg, *Special Agent*

People of the State of California v. Jeffrey Toll et al.

The National Health Care Anti-Fraud Association is very pleased to recognize the investigation and prosecution teams in the P**eople of the State of California v. Jeffrey Toll et al**. with this year's **SIRIS® Investigation of the Year Award**. This case represents a collaboration between Blue Shield of California, the Blue Cross Blue Shield Association, the Los Angeles City Attorney's Office, and the Los Angeles County District Attorney's Office.

The case began when a member of Blue Shield of California contacted the customer service call center to report a claim submitted on their behalf by Jeff Toll MD, Inc., explaining that they had never sought services from this provider. Jeffrey Toll is a licensed internal medicine physician located in Los Angeles, and the CEO and majority owner of Jeff Toll MD, Inc., who prior to the COVID-19 pandemic, had unremarkable billing practices.

That member complaint led Blue Shield's Special Investigations Unit to launch an investigation into allegations of questionable billing by Dr. Toll relating to drive-through COVID-19 testing. In October 2020, he began offering COVID-19 testing to patients through his private practice. Then in November 2020, Dr. Toll partnered with Sameday Technologies to charge insurance companies an additional fee for medical consultations each time a patient with insurance sought a COVID test.

The Sameday website falsely represented to insured patients that they were required to have a medical consultation in order to receive a COVID test. Insured customers were targeted, and then directed to Jeff Toll MD, Inc., for the consultation, which typically occurred over the phone. Patients paying cash were not required to have a consultation.

In exchange for having customers sent to his practice, Dr. Toll paid a substantial portion of his profits to Sameday as a "referral fee." Jeff Toll MD, Inc. employed doctors across the country to perform the telehealth consultations. In fact, very few were performed by Dr. Toll himself. Claims would be filed to insurers that did not accurately reflect the complexity or length of the consultations, misrepresented the purpose of the tests and consultations, and sought reimbursement for calls and consultations that, in many cases, did not occur. Personal Protective Equipment (PPE), intended for in-person interactions was also often billed for, despite the fact that the consultations were performed via telehealth and telephone.

Blue Shield entered a case into SIRIS® summarizing its investigation and alerting insurers and law enforcement. The case entry was viewed more than 200 times by 50 NHCAA Member Organizations and Government Liaisons.

A civil case was brought by Los Angeles city and county officials, alleging that the perfunctory chats with physicians were at the heart of a fraudulent scheme that yielded millions from health insurers and capitalized on federal laws that were intended to make it easier for people to get tested for COVID-19.

In April 2022, Los Angeles County signed a settlement with Dr. Toll, requiring him to pay restitution in the amount of $2.8 million. There were additional civil penalties totaling $1.15 million. Sameday Technologies agreed to pay $22.5 million.

CONGRATULATIONS TO

LOS ANGELES COUNTY DISTRICT ATTORNEY'S OFFICE

Hoon Chun, *Head Deputy*
Seza Mikikian, *Deputy District Attorney*

LOS ANGELES CITY ATTORNEY'S OFFICE

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National Health Care Anti-Fraud Association

United States of America v. Michael Ligotti

The National Health Care Anti-Fraud Association is proud to present the investigation and prosecution teams in the case of **United States of America v. Michael Ligotti** with a 2023 **Investigation of the Year Award**. This complex, broad-reaching, multi-insurer, multi-agency case spanned seven years and involved three quarters of a billion dollars in fraudulent addiction treatment claims.

Operating out of Delray Beach, Florida, Michael Ligotti, D.O. was the most prolific addiction treatment fraud doctor ever charged by the Department of Justice. He was central to a scheme that relied on illicit brokers to funnel patients nationwide to South Florida and involved slipshod sober homes to house the addicts, corrupt treatment centers to submit exorbitant claims to insurance companies for bogus treatment, and witting laboratories to conduct multi-thousand dollar urine and blood drug tests that were never reviewed.

This complex conspiracy relied upon various criminals to operate, but none more important than Ligotti, whose signature opened the door for hundreds of millions in insurance claims. He fueled an addiction treatment fraud frenzy that preyed on some of the country's most vulnerable victims: young adults who suffered from opioid addictions. Ligotti and his co-conspirators calculated the monetary value of each insured addict and established a patient pipeline to generate hundreds of millions of dollars in fraudulent billings. Ligotti and his scheme showed no regard for patients who often overdosed and died.

Ken Daniels, an outspoken advocate against addiction treatment fraud and the voice of the Detroit Red Wings, lost his son to an overdose death while under the care of Dr. Ligotti. During Ligotti's sentencing hearing, Daniels told the judge, "We trusted a system, shame on us. We trusted Jamie was living in a safe and sober environment, overseen by qualified medical professionals and staff, only to find out after his death that Jamie had been used for financial gain, your personal gain, Michael Ligotti."

Enlisting the assistance of key SIU subject matter experts from Optum, Florida Blue, Aetna, and other insurers, the government case team set out to capture the extent of the fraud exposure attributable to Ligotti. The expansive nature of Ligotti's conspiracy made it difficult to identify which claims he was responsible for across the 50+ laboratories, treatment facilities, and sober homes involved.

A forensic data analyst was brought in to coordinate the data gathering efforts with insurer SIU and data staff. With insurer data, the case team was able to create a complex "ping-pong" report that identified claims Ligotti was responsible for, even those where Ligotti did not appear in the insurance data. This innovative approach enabled an accurate calculation of Ligotti's fraud exposure.

As part of the 137 agreements Ligotti had with South Florida sober homes and treatment centers, Ligotti would sign off on fraudulent medical tests, but only if the owners agreed to in-turn to direct their insured patients to Ligotti's medical office. Once at Ligotti's office, he billed each patient's insurance company upwards of $16,000 to $20,000 for services that were not needed or provided.

The investigation found that Ligotti was also operating a Suboxone pill mill. This helped guarantee that insured patients would return to his office repeatedly to refill their Suboxone prescriptions. Although the DEA only authorized Ligotti to treat 100 patients per month for Suboxone, he often doubled that amount. Patients told investigators that Ligotti knew Suboxone was being diverted and sold on the streets. Analysis of the Prescription Drug Monitoring Database confirmed this. Patients who received 30-day supplies often returned after just five days to receive another 30-day supply.

Michael Ligotti was convicted October 4, 2022. Upon signing a plea deal, he received a 20-year prison sentence on January 9, 2023. On April 26, 2023, he was ordered to pay $127 million in restitution.

CONGRATULATIONS TO

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Office of Inspector General

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OPTUM
Casey H. Chandler, *Investigations Consultant*

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National Health Care Anti-Fraud Association

1-800-Get-Thin United States of America v. Omidi, et al.

The National Health Care Anti-Fraud Association is proud to present the investigation and prosecution teams in the case of **1-800-Get-Thin** with a **2023 Investigation of the Year Award**. Formally United States of America v. Omidi, et al., the case involves notorious West Hollywood former dermatologist Julian Omidi and his Beverly Hills-based company Surgery Center Management, LLC (SCM).

This investigation stands as the largest health care fraud scheme in Southern California in the last 20 years. At the heart of the scheme was Julian Omidi, a former physician whose California medical license had been revoked in 2009. He, along with his brother and mother, owned and operated a marketing and healthcare empire called 1-800-Get-Thin that comprised 19 owned or leased ambulatory surgical centers. This network of entities focused on the promotion and performance of the bariatric procedure known as Lap-Band weight-loss surgeries.

Omidi established a policy requiring prospective Lap-Band patients – even those with insurance plans he knew would never cover the surgery – to undergo at least one sleep study, and employees were incentivized with commissions to make sure the studies took place. Many patients were subjected to a battery of diagnostic procedures over a period of several months. They might undergo ultrasounds, lab tests, EDGs, colonoscopies, or multiple sleep studies.

After patients underwent sleep studies and other tests and procedures – irrespective of whether any doctor had ever determined they were necessary – employees, acting at Omidi's direction, often falsified the results. Omidi then used the falsified results to support 1-800-Get-Thin's pre-authorization requests for Lap-Band surgery.

Relying on the results and documentation, insurers often authorized payment for some of the proposed Lap-Band surgeries. And even if surgery was not approved, 1-800-Get-Thin was still able to submit claims for the previous tests and procedures, including approximately $15,000 per sleep study.

Health insurer Anthem launched an investigation into Omidi in 2009, in response to numerous member complaints that coincided with a sudden and dramatic increase in Lap-Band surgeries. Through the course of its investigation, Anthem identified and monitored over 250 unique entities/TINs associated with the scheme.

The media played a key role in this case, first by helping drive business to Omidi's 1-800-Get-Thin empire through prolific billboard and radio advertising, but then also aided in its downfall through publicity around 1-800-Get-Thin's medically negligent practices, resulting in the deaths of at least five people and many malpractice lawsuits. The Anthem SIU team aided the media's reporting on 1-800-Get-Thin. As negative media attention grew, it prompted state and federal leaders to call for hearings and investigations. The increased coverage and scrutiny gave law enforcement the ability to bring more resources to bear in their investigation of 1-800-Get-Thin.

Around 2010, the FDA and the FBI launched a joint investigation into 1-800-Get-Thin and Omidi that expanded to include DCIS, IRS, and California Department of Insurance investigators. It was a complicated investigation due to its sheer size. In February 2017, the U.S. Attorney's Office, Central District of California convened a Grand Jury, which returned a 42-count indictment. After delays caused by several changes to Omidi's legal team and the COVID-19 pandemic, the case went to trial in September 2021.

At the conclusion of a three-month trial that included testimony by 150 witnesses, a federal jury in December 2021 found Omidi and SCM guilty of 28 counts of wire fraud and three counts of mail fraud. Omidi also was found guilty of two counts of making false statements relating to health care matters, one count of aggravated identity theft and two counts of money laundering. Omidi and Surgery Center Management, LLC were also found guilty of conspiracy to commit money laundering.

On April 17, 2023, Omidi was sentenced to 84 months in federal prison. Beyond Anthem, victim health care benefit programs included Aetna, Allied, Cigna, HCSC, Health Net, OPM, SC UFCW, Tricare, and UnitedHealthcare. On July 25, 2023, restitution was ordered in the amount of $11.2 million against Omidi as well as forfeiture in the amount of $98 million.

CONGRATULATIONS TO

UNITED STATES DEPARTMENT OF DEFENSE
Office of Inspector General
Defense Criminal Investigation Service

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UNITED STATES DEPARTMENT OF JUSTICE
Federal Bureau of Investigation

Mark H. Coleman, *Special Agent*

UNITED STATES DEPARTMENT OF JUSTICE
United States Attorney's Office
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David C. Lachman, *Assistant United States Attorney*
Ali Moghaddas, *Assistant United States Attorney*
Kristen A. Williams, *Assistant United States Attorney, Deputy Chief, Major Frauds Section*

UNITED STATES FOOD AND DRUG ADMINISTRATION
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AETNA
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ANTHEM, INC.
Carl Reinhardt, AHFI, CPC, *Director, SIU West*

HEALTH NET, INC.
Lisa-Noelle LeGare, AHFI, CFE,
Senior Investigator, Special Investigations Unit

Other Notable Cases

RANDY ROSEN, M.D.

In June 2020, Randy Rosen, M.D. was arrested for various insurance fraud related charges. Rosen was suspected of utilizing patient brokers to recruit patients receiving treatment for substance abuse to receive an experimental implant that was marketed to curb opioid cravings. Patients were assured their insurance companies covered the implant, and in exchange for receiving the implants, the patients were paid hundreds and in some instance thousands of dollars, depending on how many implants were received. The implants contained Naltrexone, an FDA approved drug that is safe and effective as an injection or in pill form but not as a surgical implant. The scheme involved a laboratory owned by Rosen's girlfriend, where patients were required to have urine tests prior to surgery. In August 2022, Rosen plead guilty to eight felony counts of insurance fraud and two aggravated white collar crime enhancements for a loss of over $500,000. He was sentenced to ten years in prison.

THE PILL CLUB

In August of 2018, an investigation was launched into Dr. David Svec and his two businesses (David Svec, MD Inc. and The Pill Club) for aberrant billing of CPT Codes 99212 and 99401. The services were allegedly for contraceptive counseling for teenage girls for which their parents had no knowledge of or had consented to the services. The investigation found that 289 providers were billing Dr. Svec's TIN from almost every state in the U.S. and almost every claim included a telehealth modifier for Z30.9 Contraceptive Management, Z30.016 Prescription of Transdermal, Z30.09 General Counseling and Advice of Contraception, and Z30.40 Encounter for Surveillance of Contraceptives. The claims records referenced the Pill Club. An internet search was conducted and investigators identified an internet-prescribing scheme. This type of "business model" is illegal to conduct in California. The case concluded in 2023 with a $15 million settlement.

UNITED STATES OF AMERICA V. CRUISE

An investigation was initiated in December 2015 to identify providers billing for an unusually high level of compound medications. Compounding Solutions, a pharmacy, was identified as a disproportionately high biller. The investigation determined Compounding Solutions and related entities engaged in multiple fraud schemes involving healthcare fraud, conspiracy to commit healthcare fraud, wire fraud, and violations of federal anti-kickback statue. The government paid out $42.3m in connection with this conspiracy through TRICARE and the federal worker's compensation programs. Indictments were handed down in June 2018 and agents obtained seven pretrial guilty pleas. Trial was set for October 2021 for the remaining six defendants and all six entered guilty pleas the morning the trial was set to begin.

UNITED STATES OF AMERICA V. DR. BERNARD SHELTON

Dr. Bernard Shelton operated a pill mill in St. Clair Shores, Michigan which caused the death of one of his patients. He was an internal medicine doctor in a general practice and had no special certification in pain management and did not advertise as a pain specialist. Dr. Shelton prescribed over 5.5 million doses of controlled substances between April 2013 and December 2016. He issued prescriptions outside the usual course of professional practice and for no legitimate medical purpose so he could charge for office visits, and he went to great lengths to disguise his pill mill. He saw patients and sometimes examined them, he created medical charts, documented pain levels, ordered urine drug screens and confirmatory urine lab tests, and used the PDMP (Michigan Automated Prescribing System – MAPS). The DEA led the investigation and the undercover patient visits by an investigator at BCBS Michigan were significant to the case. Dr. Shelton was the first doctor in the Eastern District of Michigan to be convicted of unlawful prescribing of controlled substances resulting in the death of a patient.

UNITED STATES OF AMERICA V. KIRK ET AL

St. Gabriel Health Clinic is a Federally Qualified Health Center that operates a main clinic and several satellite clinics housed in elementary and middle schools in Louisiana. From 2010 to 2015, the former CEO, Victor Kirk, directed social workers to teach character and educational classes to entire classrooms of students and fraudulently bill the services to Medicaid as group psychotherapy. When managed care organizations began operating in Louisiana in 2012, they began denying the group therapy services due to St. Gabriel Health clinic using “v codes” and not a medical disorder diagnosis code. In order to continue to submit fraudulent group therapy claims Kirk directed Michael Gaines, a member of his staff who is a Licensed Clinical Social Worker and social worker supervisor to begin falsely diagnosing students with mental health disorders. At the direction of Kirk, the CFO, Marilyn Antwine, who oversaw the clinic’s billers, also caused these false diagnoses and false group psychotherapy claims to be submitted to Medicaid. Antwine and Gaines were indicted, pleaded guilty, cooperated and sentenced to 14- and 12- months’ imprisonment. Kirk was found guilty after a six-day trial and was sentenced to 82 months imprisonment. The false diagnosis given to the children are still present in their medical records and case agents are still pursuing efforts to correct their records. This was a complex investigation due to the intricacies of the Federally Qualified Health Center billing. The case was originally brought to the USAO Middle District of Louisiana, Civil Section and became a case under the USDOJ Gulf Coast Strike Force and involved the USAO, USDOJ, FBI, HHS-OIG, and MFCU.

See more ▶

Other Notable Cases

UNITED STATES OF AMERICA V. WILLIAM HICKMAN, ET AL.

William Hickman was a sales representative for a pharmaceutical company who created a side business in his wife's name to sell medical products for other companies. As part of his side business, he persuaded patients who were State of New Jersey employees to receive compounded medications. The medications included metabolic supplements, scar creams, fungus creams, pain creams, and libido creams that were provided by out of state pharmacies. Most of the patients did not visit a doctor to establish a need for the prescriptions and large sums were paid in bribes and kickbacks. Healthcare professionals and public service employees including police, fire, and teachers conspired to defraud the State of New Jersy out of $100m. In addition, pharmaceutical and laboratory sales representatives, physicians and health care providers, and pharmacy business executives were charged. The case resulted in 62 arrests (52 in New Jersey), 48 convictions, $29,184,793.13 in court ordered forfeiture, $4,021,049.42 cash seized, jail sentences for 21 defendants to date, and $44,772,227.29 in court ordered restitution for the 21 defendants.

AWARDEE CONFERENCE SESSIONS

PEOPLE OF THE STATE OF CALIFORNIA V. JEFFREY TOLL ET AL.

Recipients of the NHCAA's 2023 SIRIS® Investigation of the Year Award will discuss the investigative strategies, multi-organization cooperation, and case-building excellence that led to the successful resolution of the investigation and the coveted NHCAA honor.

Wednesday, November 8, 2023
12:30 PM – 1:30 PM
Landmark Ballroom B

UNITED STATES OF AMERICA V. MICHAEL LIGOTTI

Recipients of NHCAA's 2023 Investigation of the Year Award will discuss the investigative strategies, multi-organization cooperation, and case-building excellence that led to successful resolution of the case and the coveted NHCAA honor.

Wednesday, November 8, 2023
3:00 PM – 4:15 PM
Landmark Ballroom A

1-800-GET-THIN
UNITED STATES OF AMERICA V. OMIDI, ET AL.

Recipients of NHCAA's 2023 Investigation of the Year Award will discuss the investigative strategies, multi-organization cooperation, and case-building excellence that led to successful resolution of the case and the coveted NHCAA honor.

Thursday, November 9, 2023
9:00 AM – 11:00 AM
Reunion Ballroom F

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