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Houston Doctor Gets 135 Month Health Care Fraud Sentence

A Houston Federal Court recently sentenced Houston doctor Christina Joy Clardy to 135 months in federal prison for her conviction on charges arising from a health care fraud conspiracy that federal officials charged resulted in false billings to Medicare and Texas Medicaid programs for $45,039,230 over a 2 ½-year-period. Clardy, who was found guilty of one count of conspiracy to commit health care fraud, 14 counts of health care fraud and three counts of mail fraud on May 27, 2011, after an 18-day trial in front of U.S. District Judge Melinda Harmon, also was ordered to pay $15,626,084.01 in restitution to Medicare and Medicaid.

Federal prosecutors had charged that Clardy was a key player in a massive federal health care fraud scheme under which City Nursing Services of Texas, Inc (City Nursing Services) billed more than $25 million worth of physical therapy services under Clardy's physician provider numbers between January 2007 and August 2008.

At trial, the United States introduced a letter at trial, sent by Clardy to Imo in July of 2007 - a year before she left the clinic, showing her knowledge of the fraudulent activities at the clinic, ordering Imo to immediately cease billing Medicare under her provider number, to notify Medicare of the prior fraudulent billing and threatening to notify Medicare of the fraud if he did not.

Clardy testified at trial that after Imo received her letter they had a private meeting at her house and after that she never contacted Medicare about the fraud and never asked Imo if he contacted Medicare or stopped the fraudulent billing. Other evidence introduced by the United States showed that beginning in August 2007, a few weeks after Clardy's letter, Imo began making large cash payments to Clardy and continued to bill approximately $21 million worth of false and fraudulent physical therapy services.

Clardy is the third defendant to be sentenced in this matter. Earlier in October, 2011, Umawa Oke Imo, the owner of City Nursing Services was sentenced to 327 months for his role in the conspiracy and health care fraud. City Nursing employee Joann Michelle White, previously pleaded guilty to conspiracy in February 2010 and testified for the United States during the trial. She was sentenced to 46 months on October 14, 2011. The last convicted defendant, Kenneth Anokam, s scheduled to be in November, 2011.

Charges Part of Ongoing National Anti-Health Care Fraud Campaign

The charges against Clardy and others convicted in the City Nursing Services action are one of a growing number of health care fraud prosecutions resulting from the actions of the Medicare Fraud Strike Force that are conducted as part of the Health Care Fraud Prevention & Enforcement Action Team (HEAT). HEAT is a joint initiative between the Department of Justice and HHS to focus their efforts to prevent and deter fraud and enforce current anti-fraud laws around the country. The joint Department of Justice-HHS Medicare Fraud Strike Force is a multi-agency team of federal, state and local investigators designed to combat Medicare fraud through the use of Medicare data analysis techniques and an increased focus on community policing. Since its announcement, the Strike Force has used the combined resources of agents from the FBI, HHS-Office of Inspector General (HHS-OIG), multiple Medicaid Fraud Control Units, and other state and local law enforcement agencies to investigate and prosecute a rising number of organizations and individuals throughout the industry for alleged violations of Federal health care fraud prohibitions. In their September 7, 2011 announcement, HHS and DOJ credited Strike Force Operations in nine locations with resulting in charges against more than 1,140 defendants who the government charged collectively falsely billed the Medicare program for more than $2.9 billion.

In addition, the HHS Centers for Medicare and Medicaid Services, working in conjunction with the HHS-OIG, are using a wide range of new and old tools in their campaign against what they perceive as fraudulent providers and to deter other perceived aggressiveness by health care providers and organizations. See e.g.,**U.S. to use**

software to crack down on Medicare, Medicaid, CHIP fraud; Health Care Fraud Enforcement Packs New Heat; OIG Shares Key Insights On When Owners, Officers & Managers Face OIG Program Exclusion Based On Health Care Entity Misconduct; OIG Launch of Health Care Fraud "Most Wanted" List Sign of Enforcement Risks; CMS Delegated Lead Responsibility For Development of New Affordable Care Act-Required Medicare Self-Referral Disclosure Protocol; HHS announces Rules Implementing Tools Added By Affordable Care Act to Prevent Federal Health Program Fraud.

The effectiveness of these Federal efforts to deter, find and prosecute false claims and other perceived abuses of Federal health care law has been significantly strengthened since Congress passed the Patient Protection & Affordable Care Act (Affordable Care Act). Among other things, ACA empowered HHS to:

- Suspend payments to providers and suppliers based on credible allegations of fraud in Medicare and Medicaid;
- Impose a temporary moratorium on Medicare, Medicaid, and CHIP enrollment on providers and suppliers when necessary to help prevent or fight fraud, waste, and abuse without impeding beneficiaries' access to care.
- Strengthen and build on current provider enrollment and screening procedures to more accurately assure that fraudulent providers are not gaming the system and that only qualified health care providers and suppliers are allowed to enroll in and bill Medicare, Medicaid and CHIP;
- Terminate providers from Medicaid and CHIP when they have been terminated by Medicare or by another state Medicaid program or CHIP;
- Require provider compliance programs, now required under the Affordable Care Act, that will ensure providers are aware of and comply with CMS program requirements.

Act To Manage Risks

In response to the growing emphasis and effectiveness of Federal officials in investigating and taking action against health care providers and organizations, health care providers covered by federal false claims, referral, kickback and other health care fraud laws should consider auditing the adequacy of existing practices, tightening training, oversight and controls on billing and other regulated conduct, reaffirming their commitment to compliance to workforce members and constituents and taking other appropriate steps to help prevent, detect and timely redress health care fraud exposures within their organization and to position their organization to respond and defend against potential investigations or charges.

For More Information Or Assistance

If you need assistance reviewing or responding to these or other health care related risk management, compliance, enforcement or management concerns, the author of this update, attorney Cynthia Marcotte Stamer, may be able to help. Vice President of the North Texas Health Care Compliance Professionals Association, Past Chair of the ABA Health Law Section Managed Care & Insurance Section and the former Board Compliance Chair of the National Kidney Foundation of North Texas, Ms. Stamer has more than 24 years experience advising health industry clients about these and other matters. Her experience includes advising hospitals, nursing home, home health, rehabilitation and other health care providers and health industry clients to establish and administer compliance and risk management policies; prevent, conduct and investigate, and respond to peer review and other quality concerns; and to respond to Board of Medicine, Department of Aging & Disability, Drug Enforcement Agency, OCR Privacy and Civil Rights, HHS, DOD and other health care industry investigation, enforcement and other compliance, public policy, regulatory, staffing, and other operations and risk management concerns.

A popular lecturer and widely published author on health industry concerns, Ms. Stamer continuously advises health industry clients about compliance and internal controls, workforce and medical staff performance, quality, governance, reimbursement, and other risk management and operational matters. Ms. Stamer also publishes and speaks extensively on health and managed care industry regulatory, staffing and human resources, compensation and benefits, technology, public policy, reimbursement and other operations and risk management concerns. Her presentations and programs include How to Ensure That Your Organization Is In Compliance With Regulations Governing Discrimination, as well as a wide range of other workshops, programs and publications on discrimination and cultural diversity, as well as a broad range of compliance, operational and risk management, and other health industry matters.

Her insights on these and other related matters appear in the Health Care Compliance Association, Atlantic Information Service, Bureau of National Affairs, The Wall Street Journal, Business Insurance, the Dallas Morning News, Modern Health Care, Managed Healthcare, Health Leaders, and a many other national and local publications. You can get more information about her health industry experience **here**. If you need assistance responding to concerns about the matters discussed in this publication or other health care concerns, wish to obtain information about arranging for training or presentations by Ms. Stamer, wish to suggest a topic for a future program or update, or wish to request other information or materials, please contact Ms. Stamer via telephone at (214) 452-8297 or via e-mail **here**.

If you or someone else you know would like to receive future updates about developments on these and other concerns from Ms. Stamer, see **here**. If you find this of interest, you also be interested reviewing some of her other writings including:

- **OCR Settlements Show Health Care & Disabled Housing Providers Face Growing Disability Discrimination Risks**
- **Physician's Suspension Shows Complying With Medical Board Orders Critical**
- **Minimum Wage, Overtime Risks Highlighted By Labor Department Strike Force Targeting Residential Care & Group Homes**
- **Health Care Fraud Enforcement Packs New Heat**
- **President Signs Long-Sought Red Flag Rule Exemption Into Law**
- **Quality, Recordkeeping & Unprofessional Conduct Lead Reasons For Medical Board Discipline of Physicians**
- **Affordable Care Act To Require Health Plans Cover Contraception & Other Women's Health Procedures In 2012**
- **Guidance For 2012 Branded Prescription Drug Fee Filings Released**
- **Medicare Fraud Strike Force Charges Against 91 Individuals For Falsely Billing $295 Million Latest Reminder Of Industry-Wide Enforcement Risk**
- **DEA Cautions Practitioners Must Restrict Delegation of Controlled Substance Prescribing Functions, Urges Adoption of Written Policies & Agreements**