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# Maxim Health Services Exec Becomes 9th Former Employee Sentenced For Involvement In Medicare False Claims Scheme

***Eight Others, Including Senior Managers, Previously Sentenced for Felony Charges Arising out of Maxim's Activities***

The sentencing of another former Maximum Healthcare Services, Inc. ("Maxim") employee last week highlights the risks that health care management employees and consultants face when they participate in activities leading to false billing of Medicare or other federal programs by the health care provider organizations that they work with.

On November 21, 2011, a Federal judge sentenced former Maxim senior manager Brian Lee Shipman to five months in prison and five months of home confinement with electronic monitoring for his involvement in the unlicensed operation of Maxim office that billed nearly a million dollars to government health care programs. In addition to the prison term, Judge Thompson sentenced Shipman to two years of supervised release and ordered him to pay a $10,000 fine. In his sentencing, Shipman became the eighth former Maximum employee sentenced for helping Maxim submit false charges to Medicare for health care services for services provided through an unlicensed facility. Maxim coughed up Shipman and other workers who helped to orchestrate and administer the billing scheme as part of a plea agreement reached with the Justice Department in September.

The sentencing of Shipman and the 8 other individual Maxim defendants criminally convicted in connection with the false billing shows that while health care organizations often pay significant fines to resolve health care fraud charges, the highest price tends to be paid by the individual employees and consultants convicted of orchestrating or participating in the activities underlying the fraud charges. Maxim shows that both health care organizations and their people need a clear understanding what activities expose them to prosecution under federal health care fraud laws and how to respond when and if asked to participate in, or confronted with ongoing practices within their organization, that may violate these laws.

## Maxim False Claims

On Sept. 12, 2011, Maxim – one of the nation's leading providers of home healthcare services – entered into a settlement agreement to resolve criminal and civil charges relating to a nationwide scheme to defraud Medicaid programs and the Veterans Affairs program of more than $61 million. Maxim was charged in a criminal Complaint with conspiracy to commit health care fraud, and entered into a Deferred Prosecution Agreement ("DPA") with the Department of Justice. The agreement allows Maxim to avoid a health care fraud conviction on the charges if it complies with the DPA's requirements. As required by the DPA, Maxim agreed to pay approximately $150 million – a criminal penalty of $20 million and approximately $130 million in civil settlements in the matter, including to settle federal False Claims Act claims.

## Shipman Sentencing

A 13-year Maxim employee, Shipman pleaded guilty in Trenton federal court on June 17, 2010, to an Information charging him with one count of health care fraud. Shipman was charged in connection with his role as a regional account manager supervising Maxim's decision to open and operate Maxim's Gainesville, Ga., office without a license from 2008 through 2009, when he and others directed billings from that office to be submitted for reimbursement by the Medicaid program as if they were from another, licensed office. Shipman entered his guilty plea before U.S. District Judge Anne E. Thompson, who also imposed the sentence today in Trenton federal court.

Shipman is one of nine individuals – eight former Maxim employees, including three senior managers, and the parent of a former Maxim patient – to have pleaded guilty to and been sentenced on felony charges arising out of the submission of fraudulent billings to government health care programs, the creation of fraudulent documentation associated with government program billings, or false statements to government health care program officials regarding Maxim's activities.

According to documents filed in this and related cases and statements made in court, Shipman, as a regional account manager, reported directly to one of two nationwide vice presidents, who in turn reported to Maxim's president. He also managed 13 offices in 2008 with hundreds of employees and total annual sales of more than $42 million, much of which derived from government programs. In his last full year of employment, Shipman earned more than $325,000, and was among the top 25 individuals at Maxim in terms of compensation out of the more than 80,000 individuals employed by Maxim in that year.

Shipman's annual compensation – which ranked him within the top .03% of the Company – was based to a significant degree on meeting sales goals. Shipman said his superiors demanded levels of growth based "not on any market analysis, but simply on a belief that dramatic growth was necessary regardless of market conditions." It was in response to that pressure, Shipman said, that he authorized and supervised the unlicensed operation of the Gainesville office.

At one point, when Maxim employees believed a state regulator would be visiting the office, lower-level employees were directed by Shipman and others to provide false information to the state regulator in an effort to prevent the Medicaid program from learning about the unlicensed operation of the office.

**8 Other Maxim Employees Previously Sentenced**

The other eight individuals who pleaded guilty were sentenced by Judge Thompson as follows:

- Gregory Munzel, 35, of Charleston, S.C., a regional account manager reporting directly to a vice president, responsible for Maxim offices throughout the southeastern United States, pleaded guilty on Dec. 4, 2009, to one count of making false statements relating to health care fraud matters. During his plea hearing, Munzel admitted that he was aware individuals he supervised were submitting time cards for work that had not actually been done – a practice Munzel said was in response to pressure from Maxim superiors to increase revenue. Munzel also acknowledged forging caregiver credentials such as CPR cards throughout his time at Maxim, in order to make it appear that the caregivers were properly credentialed, when they were not. Munzel indicated he learned the practice from his supervisors when he first joined Maxim, and that those under him engaged in the practice when he took on a leadership role with the company. Munzel was sentenced on Sept. 29, 2011, to three months of home confinement as part of a two-year term of probation. Munzel was also ordered to pay a $1,000 fine.
- Matthew Skaggs, 39, was employed as a regional account manager, reporting directly to a vice president, responsible for Maxim's offices in Texas. He pleaded guilty on Sept. 23, 2010, to making false statements relating to health care fraud matters. During his plea hearing, Skaggs acknowledged having knowingly made false statements to a surveyor from Texas' Medicaid Program, who was investigating the operation of an unlicensed Maxim office in Houston. Skaggs was sentenced on June 10, 2011, to a three-year term of probation and ordered to pay a $4,000 fine.
- Andrew Sabbaghzadeh, 30, of Clay, N.Y., was employed as an account manager; and Jason Bouche, 27, of Paradise Valley, Ariz., was employed as a recruiter at Maxim's Tempe, Ariz. office. They pleaded guilty to health care fraud on Nov. 4, 2009, and April 23, 2010, respectively. During their plea hearings, Sabbaghzadeh and Bouche acknowledged creating fraudulent time cards in order to bill government programs. They acknowledged that in some instances, Maxim employees cut signatures from legitimate time cards and pasted them onto forged time cards in order to submit them for reimbursement. Sabbaghzadeh was sentenced on Sept. 26, 2011, to six months of home confinement as part of a three-year term of probation. Sabbaghzadeh was also ordered to pay a $2,000 fine. Bouche was sentenced on Nov. 17, 2011, to a two-year term of probation and ordered to pay a $500 fine.
- Donna Ocansey, 49, of Medford, N.J., was employed as a director of clinical services (supervising nurse) in Maxim's Cherry Hill, N.J., office. She pleaded guilty on May 28, 2010, to making false statements relating to health care fraud matters. Ocansey, a registered nurse (RN), had responsibility for, among other things, ensuring that Medicaid-required supervisory visits of patients were conducted periodically – meaning that an RN periodically visited each patient to check each patient's condition and the care the patient was receiving from Maxim Home Health Aides, who lack the skills and training of RNs. During her plea hearing, Ocansey acknowledged that she fabricated documentation in order to make it appear that other nurses had conducted Medicaid-mandated supervisory visits, when in fact they had not. Ocansey stated that she fabricated documentation in response to pressure from her superiors at Maxim, who expected her to make sure that all supervisory visits were completed without providing adequate resources for her to do so. Ocansey was sentenced on Oct. 18, 2011, to four months of home confinement as part of a three-year term of probation. Ocansey was also ordered to pay a $2,000 fine.
- Mary Shelly Janvier-Pierre, 43, of Lake Worth, Fla., and Sandy Cave, 39, of West Palm Beach, Fla., pleaded guilty to health care fraud on Feb. 1, 2010, and June 21, 2010, respectively. During their plea hearings, Janvier-Pierre, who had been employed by Maxim's West Palm Beach office as a licensed practical nurse; and Cave, the mother of a former pediatric patient of Maxim, admitted to their roles in a scheme to fraudulently bill Medicaid, through Maxim, for services that were not rendered. Janvier-Pierre and Cave acknowledged that they agreed to submit billings as if Janvier-Pierre was taking care of Cave's child, when she was not. Janvier-Pierre and Cave then split the money Janvier-Pierre received for purportedly providing the care. As a result of the scheme, Maxim was paid more than $70,000 by Florida's Medicaid program. Janvier-Pierre was sentenced on Sept. 21, 2011, to six months of home confinement as part of a three-year term of probation. Cave was sentenced on Nov. 17, 2011, to five months of home confinement as part of a three-year term of probation. Cave was also ordered to pay a $1,000 fine.
- Marion Morton, 45, of North Charleston, S.C., was employed as a home health aide and personal care assistant by Maxim's Charleston, S.C., office. He pleaded guilty on May 3, 2010, to one count of making false statements relating to health care fraud matters. During his plea hearing, Morton acknowledged that, at the instruction of Maxim employees, he fabricated timecards reflecting work he had not done. On multiple occasions, Maxim submitted bills to Medicaid based

on timecards which showed he worked more than 24 hours on certain days. Morton was sentenced on May 24, 2011, to a three-year term of probation and ordered to pay a $5,000 fine.

The Maxim charges against these defendants were investigated and prosecuted by the Department of Justice with the involvement of the Department of Health & Human Services and other agencies participating in the Medicare Fraud Strike Force. Since their inception in March 2007, the Medicare Fraud Strike Force operations in nine districts have charged thousands of individuals with falsely billing Medicare or more than $2.9 billion.

The rising emphasis of DOJ, HHS and other federal and state officials on health care fraud detection and enforcement requires that health care providers tighten their billing, medical recordkeeping, training and other compliance efforts to guard against false claims and other health care fraud charges. The Maxim prosecution and sentencing of senior employees who participated in the prohibited billings highlights that both health care organizations and their management employees face risks for participating in prohibited or other aggressive health care billing or other transactions.

Health care organizations, their management and other employees need to clearly understand the implications of federal rules prohibiting health care fraud and how to respond when confronted with practices or proposed practices that may expose them or their organizations to liability. With enforcement on the rise, both health care organizations and their people need to understand what actions are likely to violate health care fraud laws. Both organizations and their employees should participate in training and other activities to inform themselves about activities that create prosecution or other health care fraud exposures. Health care organizations should conduct compliance audits, oversight and training as well as provide access to compliance resources and hotlines.

Management and other employees should clearly understand how to respond when presented with questionable situations.

Both health care organizations and members of their team should document their compliance efforts.

Because of the potential cost of defending health care fraud charges or complaints, both health care organizations and members of their management also should consider exploring liability insurance coverage, indemnification or other resources that could help cover defense costs in the event of an investigation or charge.

Finally, in the event that a situation arises that may present health care fraud concerns, a health care organization or its employee promptly should seek competent, experienced legal advice to discuss potential exposures and how to manage them within the scope of attorney-client privilege as soon as possible.

**For Help With Compliance, Investigations Or Other Needs**

If you need assistance providing compliance or other training, 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. Ms. Stamer has extensive experience advising and assisting health care providers and other health industry clients to establish and administer medical privacy and other compliance and risk management policies, to 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/ She also regularly designs and presents risk management, compliance and other training for health care providers, professional associations and others. Her publications and insights appear in the Health Care Compliance Association, Atlantic Information Service, Bureau of National Affairs, World At Work, 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 with these or other compliance concerns, wish to inquire about arranging for compliance audit or training, or need legal representation on other matters please contact Ms. Stamer at (469) 767-8872 or via e-mail **here**.

**Other Recent Updates & Information**

If you find this of interest, you also be interested reviewing some of our other articles and publications by Ms. Stamer including:

- **Medical Identity Theft/Fraud Convictions Highlight Need For Health Care Providers To Safeguard Health Information, Guard Against Fraud Schemes**
- **Detroit-Area Foot Doctor Pleads Guilty to Medicare Fraud Scheme**
- **Merck To Pay $950 Million To Settle Vioxx® Off-Label Marketing Charges**
- **Texas Medical Board Suspends Child Psychiatrist For Sexual Misconduct**
- **100,000+ Primary Care Providers Signed Up To Get EHRs Regional Extension Centers**

- **Joint Commission Equal Visitation Rules & Guidance Supplement New Medicare Equal Visitation Requirements**
- **OCR Audit Program Kickoff Further Heats HIPAA Privacy Risks**
- **Houston Doctor Gets 135 Month Health Care Fraud Sentence**
- **Bill Extending Funding For Certain Veteran Medical and Other Projects Heads To President**
- **OCR Settlements Show Health Care & Disabled Housing Providers Face Growing Disability Discrimination Risks**
- **UCLA Health Systems Payment of $865,500 To Settle HIPAA Charges Shows Rising HIPAA Risk**
- **Indictment of 91 Shows Growing Health Care Fraud**
- **Unions Get New Tool As NLRB Changes Bargaining Units Certification Rules For Non-Acute Health Care Facilities**
- **Texas Doctor, Pharmacy Suspension Reminder of Pain Management Prescribing Risks**
- **Supreme Court Ruling Medical Resident Stipend Are Wages Highlights Advisability of Compliance Review**
- **Minimum Wage, Overtime Risks Highlighted By Labor Department Strike Force Targeting Residential Care & Group Homes**
- **DEA Cautions Practitioners Must Restrict Delegation of Controlled Substance Prescribing Functions, Urges Adoption of Written Policies & Agreements**

You can review other selected publications and resources and additional information about the employment, employee benefits and other experience of Ms. Stamer **here.**

If you or someone else you know would like to receive future updates about developments on these and other concerns, please be sure that we have your current contact information – including your preferred e-mail – by creating or updating your profile **here**. For important information concerning this communication click **here.** If you do not wish to receive these updates in the future, send an e-mail with the word "Remove" in the Subject to **here.**