JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE Monday, September 12, 2011

Maxim Healthcare Services Charged with Fraud, Agrees to Pay Approximately $150 Million, Enact Reforms After False Billings Revealed as Common Practice

Nine, Including Senior Managers, Have Pleaded Guilty to Felony Charges for Related Conduct

NEWARK, N.J. – Maxim Healthcare Services Inc., one of the nation's leading providers of home healthcare services, has entered into a settlement 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.

Today's announcement was made by Tony West, Assistant Attorney General of the Civil Division of the Department of Justice; J. Gilmore Childers, Acting U.S. Attorney for the District of New Jersey; Tom ODonnell, Special Agent in Charge of the Health and Human Services Office of Inspector General (HHS -OIG) region covering New Jersey; Michael B. Ward, Special Agent in Charge of the FBI's Newark, N.J., Field Office; and Jeffrey Hughes, Special Agent in Charge of the U.S. Department of Veterans Affairs, Office of the Inspector General (VA OIG), Northeast Field Office.

Maxim was charged today in a criminal complaint with conspiracy to commit health care fraud, and has entered into a deferred prosecution agreement (DPA) with the Department of Justice. The agreement will allow Maxim to avoid a health care fraud conviction on the charges if it complies with the DPA's requirements. As required by the DPA, which will expire in 24 months if the company meets all of its reform and compliance requirements, Maxim has agreed to pay a criminal penalty of $20 million and to pay approximately $130 million in civil settlements in the matter, including to federal False Claims Act claims.

To date, nine individuals – eight former Maxim employees, including three senior managers and the parent of a former Maxim patient – have pleaded guilty to 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.

The criminal complaint accuses Maxim, a privately-held company based in Columbia, Md., with hundreds of offices throughout the United States, of submitting more than $61 million in fraudulent billings to government health care programs for services not rendered or otherwise not reimbursable. The investigation revealed that the submission of false bills to government health care programs was a common practice at Maxim from 2003 through 2009. During that time period, Maxim received more than $2 billion in reimbursements from government health care programs in 43 states based on billings submitted by Maxim.

"Fraudulent billing for services not rendered uses patients as pawns in a game of corporate greed that puts cash over care and wastes precious taxpayer dollars," said Assistant Attorney General West. "At a time when we're all looking for ways to reduce public expenditures, settlements like this one recapture taxpayer dollars lost to fraud and abuse, and help ensure that funds are available for the vital health care programs and services that people depend on day in and day out."

"Maxim, including senior executives, defrauded a system providing needed services to turn money meant for patient care into corporate profits," said Acting U.S. Attorney Childers. "We will continue to

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prove our commitment to investigating and prosecuting both companies and individuals whose misconduct robs our nation's health care programs and those who count on them. It is our hope that Maxim, in cleaning up its own house, will be a lighthouse influencing best practices across the industry."

"Companies scheming to profit by deceiving patients and defrauding taxpayer-funded government health care programs can expect close scrutiny and aggressive investigation," said HHS-OIG Special Agent in Charge ODonnell. "We will continue to carefully guard the nation's vital health programs against those who put greed over patient care."

"Health care fraud is a considerable problem in New Jersey with residents being victimized by an estimated $7.5 billion in care-related frauds in 2010," said FBI Special Agent in Charge Ward. "The criminal conduct by Maxim in this instance was significant and systemic, which resulted in both the company and individuals being liable for their actions. The Newark Division of the FBI is committed to its stance of being among the most aggressive offices in pursuit and ultimate prosecution of health care fraud offenders."

"Today's announcement demonstrates the Department of Veterans Affairs Office of Inspector General's commitment to focus investigative resources on companies that choose to pursue profit over the public's health," said VA OIG Special Agent in Charge Hughes. "VA OIG applauds the hard work of the Department of Justice and our law enforcement counterparts in bringing about this successful conclusion by aggressively pursuing and prosecuting those who committed fraud against our nation's federal healthcare programs, including VA's."

As part of the DPA, Maxim has stipulated to a statement of facts which mirrors the language of the criminal complaint. In the event that Maxim fails to comply with the provisions of the DPA, Maxim has agreed that the U.S. Attorney's Office may proceed with its prosecution of Maxim and use the agreed-upon statement of facts against it in the prosecution.

As detailed in the criminal complaint, Maxim, through its former officers and employees, falsely and fraudulently submitted billings to government health care programs for services not rendered or otherwise not reimbursable by government health care programs from 2003 through 2009. In order to conceal the fraud, Maxim's former officers and employees engaged in various conduct during that time period, including creating or modifying time sheets to support billings to government health care programs for services not rendered. They also submitted billings through licensed offices for care actually supervised by offices which operated without licenses and whose existence was concealed from government health care program auditors and investigators. Additionally, they created or modified documentation relating to required administrative functions associated with billings submitted to government health care programs, including documentation reflecting required training and qualifications of caregivers.

The DPA obliges Maxim to continue cooperating in the government's ongoing federal and state criminal investigation of former Maxim executives and employees responsible for the alleged conduct at issue, and to develop and operate an effective corporate compliance and governance program that includes adequate internal controls to prevent the recurrence of any improper or illegal activities.

The DPA requires Maxim's acceptance and acknowledgment of full responsibility for the conduct that led to the government's investigation.

The settlement requires payment of approximately $130 million to Medicaid programs and the Veterans Affairs program to resolve False Claims Act liability for false home healthcare billings to Medicaid programs and the Veterans Administration under civil agreements relating to this matter. The settlement resolves allegations that Maxim billed for services that were not rendered, services that were not properly documented, and services performed by 13 unlicensed offices. Maxim has agreed to pay approximately $70 million to the federal government and approximately $60 million to 42.

Also included in the settlement is a corporate integrity agreement with HHS-OIG, which requires additional reforms and monitoring under HHS-OIG supervision.

In addition, the company must also retain and pay an independent monitor, who will review Maxim's business operations and regularly report concerning the company's compliance with all federal and state health care laws, regulations, and programs. The monitor was selected by the U.S. Attorney's Office, consistent with U.S. Department of Justice guidelines, after a review of monitor candidates and in consultation with the company. Maxim will be monitored by Peter Keith of the law firm Gallagher, Evelius & Jones, which is headquartered in Baltimore.

Prosecution of Individuals

According to documents filed in these cases and statements made in Trenton, N.J., federal court:

Gregory Munzel, 35, of Charleston, S.C., was employed as a regional account manager, reporting directly to a vice president, responsible for Maxim offices throughout the southeastern United States. He 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 is currently scheduled to be sentenced Sept. 29, 2011.

Bryan Lee Shipman, 38, of Athens, Ga., worked for Maxim for 13 years, the last eight as a regional account manager, reporting directly to a vice president. He pleaded guilty on June 17, 2010, to one count of health care fraud. During his plea hearing, Shipman acknowledged that Maxim's Gainesville, Ga., office operated without a license from 2008 through 2009, and that he and others directed billings from that office to be submitted as if they were from another, licensed office to be approved for reimbursement by the Medicaid program. At one point, when Maxim employees believed a state regulator would be visiting the office, lower-level employees were directed 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. 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." Shipman is currently scheduled to be sentenced Nov. 16, 2011.

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, 29, 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 is currently scheduled to be sentenced on Sept. 26, 2011; Bouche is currently scheduled to be sentenced on Nov. 17, 2011.

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, had responsibility for, among other things, ensuring that Medicaid-required supervisory visits of patients were conducted periodically – meaning that a registered nurse 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 registered nurses. 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 is currently scheduled to be sentenced Sept. 20, 2011.

Mary Shelly Janvier-Pierre, 42, 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 in reality 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 and Cave are scheduled to be sentenced on Sept. 21, 2011, and Oct. 24, 2011, respectively.

Marion Morton, 45, of North Charleston, S.C., was employed as a home health aide and personal care assistant by Maxim's Charleston 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.

All of the defendants pleaded guilty before U.S. District Judge Anne E. Thompson in Trenton federal court.

The health care fraud charge to which Shipman, Sabbaghzadeh, Bouche, Janvier-Pierre and Cave pleaded guilty carries a maximum penalty of 10 years in prison and a maximum fine of $250,000, or twice the amount of loss caused by their offenses. The false statements relating to health care fraud matters charge to which defendants Munzel, Skaggs, Ocansey and Morton pleaded guilty carries a maximum penalty of five years in prison and a maximum fine of $250,000, or twice the amount of loss caused by their offenses.

Maxim's Remedial Actions

The government's willingness to enter into a DPA with Maxim is due, in significant part, to the company's cooperation and the reforms and remedial actions the company has taken – beginning particularly in May 2009 – including significant personnel changes: terminating senior executives and other employees the company identified as responsible for the misconduct; establishing and filling of positions of chief executive officer, chief compliance officer, chief operations officer/chief clinical officer, chief quality officer/chief medical officer, chief culture officer, chief financial and strategy officer, and vice president of human resources; and hiring a new general counsel.

The company has identified and disclosed to law enforcement the misconduct of former Maxim employees, including providing information which has been critical in obtaining the convictions of some of the individuals who have pleaded guilty to date. The company has also significantly increased the resources allocated to its compliance program.

The settlement arises from a lawsuit filed under the False Claims Act. Under the qui tam, or whistleblower, provisions of the act, private citizens may file actions on behalf of the United States and share in any recovery. The whistleblower will receive approximately $15.4 million as his share of the recoveries from the federal government and the states.

The criminal complaint, DPA, civil settlement agreement and guilty pleas are the culmination of a multi-year investigation conducted jointly by special agents and investigators from HHS-OIG, under the direction of Special Agent in Charge ODonnell; FBI, under the direction of Special Agent in Charge Ward; and VA OIG, under the direction of Special Agent in Charge Hughes. The National Association of Medicaid Fraud Control Units (NAMFCU) and the Medicaid Fraud Control Units of the New Jersey, Virginia and Massachusetts Attorney General's Offices also assisted in coordinating the settlements with the various states.

The government is represented in the prosecution of the criminal case by Assistant U.S. Attorney Jacob T. Elberg of the U.S. Attorney's Office Health Care and Government Fraud Unit in Newark; and in the civil agreement by Sara McLean of the Department of Justice's Commercial Litigation Branch, Frauds Section and Assistant U.S. Attorney Alex Kriegsman of the U.S. Attorney's Office's Civil Division.

The government's involvement in this case is part of the United States' emphasis on combating health care fraud and another step for the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which was announced by Attorney General Eric Holder and Kathleen Sebelius, Secretary of the Department of Health and Human Services in May 2009. The partnership between the two departments has focused efforts to reduce and prevent Medicare and Medicaid financial fraud through enhanced cooperation. One of the most powerful tools in that effort is the False Claims Act, which the Justice Department has used to recover more than $5.9 billion since January 2009 in cases involving fraud against federal health care programs. The Justice Department's total recoveries in False Claims Act cases since January 2009 are more than $7.5 billion.

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