**UNITED STATES DISTRICT COURT**

**MIDDLE DISTRICT OF LOUISIANA**

**INDICTMENT FOR HEALTH CARE FRAUD**

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| UNITED STATES OF AMERICA | : | CRIMINAL NO. 18- 85-JWD-RLB |
| | : | |
| *versus* | : | |
| | : | 18 U.S.C. § 1347 |
| MICHAEL DAN GAINES | : | 18 U.S.C. § 2 |

**THE GRAND JURY CHARGES**:

**Background**

**Medicaid Generally**

1. Medicaid was a federal and state funded health insurance program designed to provide medical assistance to persons whose income and resources were insufficient to meet the costs of necessary care and services, and was a "medical assistance program," as defined by Title 42, United States Code, Section 1396 of Title XIX of the Social Security Act.

2. Medicaid was a "health care benefit program" within the meaning of Title 18, United States Code, Section 24(b).

3. Medicaid was administered by the United States Department of Health and Human Services, through its agency, the Centers for Medicare and Medicaid Services ("CMS").

4. CMS contracted with the Louisiana Department of Health and Hospitals ("DHH") to manage the Medicaid program in Louisiana, including the enrollment of medical service providers ("providers") and the processing of claims for services rendered to Medicaid recipients.

5. As part of the Medicaid enrollment process, providers submitted provider enrollment applications to Medicaid. As part of the application, providers would be required to certify that any services for which they would seek reimbursement from Medicaid were medically necessary. Provider enrollment certifications further stated that any false claims, statements, or documents, or concealment of a material fact, could be prosecuted under applicable federal and state laws.

6. Upon enrollment in the Medicaid program, providers were furnished with a letter containing specific instructions on how to access the "Provider Manual" through DHH's website, which was maintained under the authority of DHH and set forth the terms and conditions under which payment would be made for services rendered.

7. Medicaid required providers to maintain complete and accurate records reflecting the medical assessments and diagnoses of Medicaid beneficiaries as well as records documenting treatment and other services provided (*e.g.*, progress notes). The supporting documentation was not submitted to Medicaid. Rather, providers were required to retain such documentation at their premises and produce these documents upon request by Medicaid or their contracted carriers.

8. Upon providing services to beneficiaries, Medicaid-enrolled providers submitted claims to Medicaid, typically electronically, seeking reimbursement for the cost of services rendered. Medicaid's practice of reimbursing providers per service rendered, through a fiscal intermediary, was commonly referred to as a "fee-for-service" payment structure.

9. When seeking reimbursement from Medicaid, providers submitted the cost of the service provided together with the appropriate "procedure code," as defined by the American Medical Association and set forth and maintained in the Current Procedural

Terminology ("CPT") Manual, which was a uniform and universally recognized system of medical services coding that assigned numeric designations or procedure codes to individual medical procedures. Additionally, the CPT Manual defined the procedural and medical requirements that must be met in order for a provider to bill for a particular medical service.

10. Moreover, in seeking reimbursement from Medicaid, claims submitted by providers included diagnostic codes, which classified, among other things, beneficiaries' conditions, disorders, and diseases, utilizing codes set forth in International Classification of Diseases, 9th Revision ("ICD-9"). Together, the diagnosis codes and procedure codes identified for Medicaid the reasons for treatment and the treatments provided. If services rendered by providers were medically necessary to treat beneficiaries' diagnosed conditions, Medicaid appropriately reimbursed those claims. Conversely, if providers rendered services that were not medically necessary to treat diagnosed conditions, such claims were not appropriately reimbursed by Medicaid.

11. Although providers submitted the cost of the service provided, Medicaid reimbursed designated, specific amounts according to the CPT code utilized. For instance, when a provider submitted a claim utilizing CPT Code 90853, indicating that Group Psychotherapy had been provided, Medicaid would reimburse the provider between approximately $15.44 and $20.55, depending on whether the service was performed by a psychologist or other health care professional.

12. In approximately 2012, Medicaid contracted with several fiscal intermediaries in Louisiana, known as Managed Care Organizations ("MCOs"), to adjudicate claims on its behalf. One such MCO was Magellan Health Services of Louisiana, Inc. ("Magellan").

**Federally Qualified Health Centers and Encounters**

13. A Federally Qualified Health Center ("FQHC") was a center that provided health care services to residents of medically underserved urban and rural communities, including Medicaid beneficiaries. As part of their contract with Medicaid, FQHCs agreed to provide primary care services, typically that of a physician's medical practice, to Medicaid beneficiaries.

14. FQHCs could also provide services related to the diagnosis and treatment of mental illnesses, which Medicaid interpreted as the diagnosis and treatment of Axis I disorders, including mood, eating, psychotic, dissociative, and substance use disorders, as defined by the Diagnostic and Statistical Manual of Mental Disorders ("Axis I Disorders").

15. In addition to providing center-based services, FQHCs could contract with schools to provide onsite medical services to students, including students who were eligible to receive Medicaid benefits. These school-based services could include behavioral health services for the purpose of diagnosing and treating mental illness affecting the students.

16. However, Medicaid reimbursed claims submitted by FQHCs, unlike other providers, at flat rates, per "encounter," regardless of the number or types of services rendered. Whether an FQHC provided one or several services to a beneficiary on a given day, the FQHC billed Medicaid for the encounter, using an encounter code, and would be reimbursed a predetermined sum, regardless of the actual cost of the services that would otherwise have been reimbursed. Accordingly, in addition to submitting the appropriate CPT codes and ICD-9 codes (as described in paragraphs 9 and 10 above), FQHCs also utilized encounter code T1015, indicating that an all-inclusive visit had occurred. For instance, while the Medicaid reimbursement rate for a single group psychotherapy session might be approximately $15.44,

an FQHC, by using CPT Code 90853 (Group Psychotherapy) or 90857 (Interactive Group Psychotherapy), together with encounter code T1015, could submit a claim to Medicaid and be reimbursed approximately $151.83 for the "encounter" with the beneficiary.

17. Like other reimbursable procedures, Medicaid required FQHC encounters billed pursuant to encounter code T1015 to be medically necessary.

**Outpatient Therapy by Licensed Practitioners**

18. Pursuant to Medicaid rules and regulations, licensed mental health practitioners were individuals licensed in the State of Louisiana to diagnose and treat mental illness or substance abuse, acting within the scope of all applicable State laws and their professional licenses.

19. Licensed clinical social workers (LCSWs), registered social workers (RSWs), and licensed professional counselors (LPCs) were licensed mental health practitioners.

20. Medicaid required behavioral health services provided in schools by mental health practitioners to be medically necessary and provided in accordance with the student's individualized education program. Covered services included treatment and other measures, such as individual or group psychotherapy, to correct and ameliorate an identified mental health or substance abuse diagnosis, specifically, an Axis I Disorder.

21. Medicaid specifically excluded from Medicaid coverage services performed for educational purposes.

**The Defendant and St. Gabriel Health Clinic**

22. St. Gabriel Health Clinic, Inc. (St. Gabriel) was a Louisiana Non-Profit Corporation, incorporated in 1993, headquartered at 5760 Monticello Drive, St. Gabriel, Louisiana 70776. St. Gabriel was an FQHC that provided a variety of services to individuals

with both private and public health insurance, including Medicaid. In or about 1997, St. Gabriel contracted with the Iberville Parish School Board to provide medical service at East Iberville High School and Elementary School, and in or about 2011, St. Gabriel contracted with East Iberville Math, Science, and Arts Academy ("Iberville Schools"). St. Gabriel employed several mental health practitioners to provide the services.

23. **MICHAEL DAN GAINES**, the defendant herein, was a supervisory-level LCSW who began working at St. Gabriel in 2011. **GAINES'** duties included assessing and diagnosing students in need of behavioral health services at the Iberville Schools, providing behavioral health therapy, preparing progress notes for the services that he performed, reviewing and approving progress notes for the services provided by other St. Gabriel-employed practitioners at the Iberville Schools that he supervised.

**COUNTS 1—3**

**Health Care Fraud**
**(18 U.S.C. § 1347)**

24. Paragraphs 1 through 23 of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

25. Beginning in or about 2011 and continuing through in or around June 2015, in the Middle District of Louisiana, and elsewhere, the defendant, **MICHAEL DAN GAINES**, in connection with the delivery of and payment for health care benefits, items, and services, knowingly and willfully did execute and attempt to execute a scheme and artifice to defraud a healthcare benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), that is, Medicaid, and other health care benefit programs, and to obtain, by

means of material false and fraudulent pretenses, representations, and promises, money owned by and under the custody and control of Medicaid, and other health care benefit programs.

**Manner and Means**

26. In furtherance of the scheme and to accomplish its object, **GAINES** and others used the following manner and means:

a. At the beginning of each school year, St. Gabriel employees collected parental consent forms from the students enrolled at the Iberville Schools. These consent forms allowed St. Gabriel employees to provide general medical services, such as nursing services and behavioral health services, to students at the Iberville Schools over the course of a school year without having to notify parents every time such services were performed.

b. Pursuant to these consent forms and unbeknownst to many parents, St. Gabriel practitioners, including **GAINES**, performed psychological assessments of students, including Medicaid beneficiaries, to determine what, if any, behavioral health services students may have needed.

c. St. Gabriel practitioners, including **GAINES**, provided character development seminars and other educational character building programs ("Educational Services") to entire classrooms of students at the Iberville Schools during regular class periods. These seminars were educational in nature, provided in large group settings, and not tailored to any particular student's individualized educational program.

d. As **GAINES** and others provided the Educational Services, others at St. Gabriel submitted false claims to Medicaid and other programs representing that St. Gabriel had actually provided group psychotherapy, utilizing both encounter code T1015 and CPT Codes 90853 and 90857. Because of St. Gabriel's status as an FQHC, St. Gabriel was able to bill Medicaid for amounts far higher than a non-FQHC would have been able to bill for the same purported services.

e. In approximately 2012, Medicaid, through Magellan, stopped paying St. Gabriel's claims for group psychotherapy and notified St. Gabriel that future claims for group psychotherapy would only be paid if the claims also indicated that the specific beneficiaries receiving the services had been diagnosed with Axis I Disorders.

f. In response, to facilitate St. Gabriel's ability to continue billing Medicaid for the Educational Services and maximize St. Gabriel's reimbursements from Medicaid, **GAINES**, and others known and unknown to the grand jury, caused St. Gabriel practitioners to record that students who attended St. Gabriel's seminars had been diagnosed with Axis I Disorders. That is, for many students within the Iberville Schools for whom St. Gabriel had a signed consent form on file and who had attended one of St. Gabriel's educational seminars, **GAINES** and others documented in the student's medical file that the student was suffering from an Axis I disorder. For hundreds of students, **GAINES** and others falsely recorded that the students had been diagnosed with serious mental disorders such as adjustment reactive disorder, reactive attachment disorder, acute stress reactions, gender identity disorder, and other conditions, without regard to whether such diagnoses were accurate or had any basis in fact.

g. Once the students had been "diagnosed" with such a disorder, **GAINES** and others would create, complete, and certify progress notes each time **GAINES** and others visited the students' classrooms and provided Educational Services. These progress notes would reiterate the previously diagnosed Axis I disorder and then describe the nature of the services that **GAINES** and others had purportedly provided as part of St. Gabriel's treatment.

h. Based on the false diagnoses and the subsequent progress notes prepared and certified by **GAINES** and others he supervised, St. Gabriel submitted fraudulent claims to Medicaid and other health care benefit programs indicating (i) that St. Gabriel was providing group psychotherapy (when in fact St. Gabriel was providing Educational Services) and (ii) that the students receiving the services required treatment for Axis I Disorders (when in fact they did not). From the Fall of 2011 through Spring of 2015, St. Gabriel's claims to Medicaid for purported group psychotherapy totaled more than $1.8 million.

i. To conceal the fraudulent claims, among other things, neither **GAINES** nor anyone else at St. Gabriel ever informed the parents or guardians of students at the Iberville Schools that their children were diagnosed with Axis I Disorders, nor that their children were receiving psychotherapy treatments at the Iberville Schools, despite the fact that the diagnoses could remain in the students' medical records for years.

**Acts in Execution of the Scheme**

27. In order to execute and attempt to execute the scheme to defraud and to obtain money and property, and to accomplish the objects of the scheme, the defendant, **MICHAEL DAN GAINES** committed, caused others to commit, and aided and abetted others in committing the following acts within the Middle District of Louisiana, that is, on or about the dates listed below, **GAINES** caused the following false and fraudulent claims to be submitted

to Medicaid, and aided and abetted the submission of such claims, which claims indicated that group psychotherapy services had been rendered to beneficiaries with diagnoses for Axis I Disorders, when in reality, the Axis I Disorders were falsely assigned in order to bill for group psychotherapy that was neither provided nor medically necessary:

| Count | Beneficiary | Diagnosis Code Billed | Code Billed | Claim Number | Service Date | Amount Paid | Date Paid |
|---|---|---|---|---|---|---|---|
| 1 | J.A. | 308.3 – Acute Stress Reaction 309.4 – Adjustment Disorder | T1015 90853 | 4093135941700 4093135941800 | 03/19/2014 03/19/2014 | $158.81 $0.00 | 03/26/2014 |
| 2 | R.H. | 309.4 – Adjustment Disorder | T1015 90853 | 4149135002500 4149135002600 | 05/13/2014 05/13/2014 | $158.81 $0.00 | 05/21/2014 |
| 3 | D.G. | 308.3 – Acute Stress Reaction | T1015 90853 | 5071138649400 5071138649500 | 05/20/2014 05/20/2014 | $158.81 $0.00 | 03/09/2015 |

Each of the above is a violation of Title 18, United States Code, Sections 1347 and 2.

UNITED STATES OF AMERICA, by

BRANDON J. FREMIN
UNITED STATES ATTORNEY

JARED L. HASTEN
TRIAL ATTORNEY
CRIMINAL DIVISION, FRAUD SECTION
UNITED STATES DEPARTMENT OF JUSTICE

JESSICA M.P. THORNHILL
ASSISTANT UNITED STATES ATTORNEY

**A TRUE BILL**

**REDACTED PER PRIVACY ACT**

GRAND JURY FOREPERSON

6/21/18
DATE