UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

vs.

BRENDA GRIFFITH

Defendant.

CASE NO. 2:20-cr-91

JUDGE Graham

INFORMATION

18 U.S.C. §1347
21 U.S.C. §846

UNITED STATES ATTORNEY CHARGES:

At all times relevant to this Information:

I. INTRODUCTION

1. The defendant, BRENDA GRIFFITH, resided in the Southern District of Ohio.
2. The defendant, BRENDA GRIFFITH, owned and operated Reasonable Choices, Inc. (hereinafter RCI) which, during the relevant times, was located at 738 N. Limestone Street, Springfield, OH 45502. At all relevant times, RCI was located within the Southern District of Ohio.
3. RCI proclaimed to be a non-profit outpatient treatment center dedicated to treating patient with opioid addiction. RCI was an office-based opioid treatment facility (OBOT).

II. CONTROLLED SUBSTANCES ACT

4. The Controlled Substances Act ("CSA") governed the manufacture, distribution, and dispensing of controlled substances in the United States. With limited exceptions, the

CSA made it "unlawful for any person knowingly or intentionally" to "distribute or dispense . . . a controlled substance" or conspire to do so.

5. The term "controlled substance" meant a drug or other substance included in Schedules I, II, III, IV, and V of the CSA. The term "dispense" meant to deliver a controlled substance to an ultimate user or research subject by, or pursuant to the lawful order of, a practitioner; it included the prescribing and administering of a controlled substance. The term "distribute," meant to deliver (other than by administrating or dispensing) a controlled substance. The term "practitioner" meant a physician, medical doctor, dentist, or other person licensed, registered, or otherwise permitted by the United States or the jurisdiction in which he or she practiced, to distribute a or dispense a controlled substance in the course of professional practice.

6. Individual practitioners who wanted to distribute or dispense controlled substances in the course of professional practice were required to register with the Attorney General of the United States ("Attorney General") before they were legally authorized to do so. Such individual practitioners were assigned a registration number by the Drug Enforcement Administration ("DEA").

7. Practitioners registered with the Attorney General were authorized under the CSA to write prescriptions for, or to otherwise dispense Schedule II, III, IV, and V controlled substances, so long as they complied with the requirements of their registrations. 21 U.S.C. § 822(b). The CSA prohibited any person from knowingly and intentionally using a DEA registration number issued to another person in the course of distributing or dispensing a controlled substance.

8. For medical doctors, compliance with the terms of their registrations meant that they could issue a prescription for a controlled substance to a patient only if the prescription was "issued for a legitimate medical purpose by an individual practitioner acting in the usual course of professional practice." 21 C.F.R. §1306.04(a). A doctor violated the CSA and Code of Federal Regulations if he issued a prescription for a controlled substance outside the usual course of professional medical practice and not for a legitimate medical purpose. Such knowing and intentional violations subjected the doctor to criminal liability under Section 841(a) of Title 21, Untied States Code. 21 C.F.R. § 1306.04(a).

9. The CSA's "scheduling" of controlled substances was based on their potential for abuse, among other considerations. There are five schedules of controlled substances: Schedules I, II, III, IV, and V. Drugs that had a high potential for abuse and could lead to severe psychological or physical dependence were classified as Schedule II controlled substances. Drugs that had a potential for abuse and could lead to moderate or low physical dependence or high psychological dependence were classified as Schedule III controlled substances. Drugs that had a low potential for abuse and could lead to limited physical or psychological dependence were classified as Schedule IV controlled substances. 21 U.S.C. § 812.

10. Suboxone was used to treat narcotic (opiate) addiction. Suboxone was a Schedule III drug containing a combination of buprenorphine and naloxone. Buprenorphine was an opioid medication, while naloxone was a special narcotic drug that reversed the effects of other narcotic medications. Suboxone treatment was provided under the supervision of a doctor

and was intended to be part of a complete treatment plan to include counseling and psychosocial support.

11. The State Medical Board of Ohio had additional rules and regulations that physicians must follow when prescribing office based opioid treatment (OBOT). Specifically, physicians must make the initial assessment, diagnosis of opioid dependence, and establish a treatment plan for the patient. Physicians must also ensure patients receiving OBOT were drug screened, and received counseling or other professional recovery programs.

12. In addition, the Substance Abuse and Mental Health Administration (SAMHSA) provided additional guidance to physicians who prescribed OBOT. These guidelines were provided in a Treatment Improvement Protocol (TIP 40) called the "Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction," were available online.

13. On or about October 17, 2000, Congress passed the Drug Addiction Treatment Act (DATA) which permitted qualified physicians to treat narcotic dependence with Schedules III through V narcotic controlled substances that were approved by the Food and Drug Administration (FDA) for that indication. The DATA waived the requirement for obtaining a separate DEA registration as part of a narcotic treatment program (NTP) for qualified physicians who administered, dispensed, and prescribed these specific FDA approved controlled substances. Physicians registered with the DEA as practitioners who applied and were qualified pursuant to DATA were issued a waiver (DATA Waiver) and were authorized to conduct maintenance and detoxification treatment using specifically approved schedule III, IV, or V narcotic medications. DATA Waivers were only granted

to qualified physicians. Non-physicians were not permitted to obtain a DATA Waiver. Physicians underwent additional training to become a DATA Waiver provider, and were limited in the amount of patients they could treat.

14. Suboxone was approved by the FDA to be utilized to treat drug addiction. Defendant BRENDA GRIFFITH was not a physician, nor did she have a DATA Waiver.

III. THE MEDICAID PROGRAM

15. The information provided in this section describes the victim, the health insurance program (See "Attachment A" which is incorporated into this Indictment and serves as the Fed.R.Crim.P. 12.4 Disclosure Statement).

16. Medicaid, established by Congress in 1965, provided medical insurance coverage for individuals whose incomes are too low to meet the costs of necessary medical services. Approximately 60% of the funding for Ohio's Medicaid program came from the federal government. The Ohio Department of Medicaid (ODM), Columbus, Ohio, managed the Medicaid program, which was previously managed by the Ohio Department of Job and Family Services (ODJFS). ODM received, reviewed, and obtained formal authority to make payment of Medicaid claims submitted to it by providers of health care. Medicaid contracted with Managed Care Organizations (MCOs) in order to provide care to Medicaid recipients.

17. MCOs were health insurance companies that were licensed by the Ohio Department of Insurance and contracted with ODM to provide coordinated health care to Medicaid recipients. MCOs worked with hospitals, doctors, and other health care providers to coordinate care and provided for the health care services for Medicaid recipients. Aetna,

Molina, Paramount, CareSource, Optum, and United Health Care, were MCOS that paid claims related to RCI.

18. Each qualified Medicaid patient received a recipient identification number to identify the patient as an authorized recipient of Medicaid benefits. Pursuant to the rules and regulations of the Ohio Medicaid Program, including Medicaid MCOs, Medicaid only paid for services that were actually performed by qualified individuals and medically necessary for the patient's health.

19. In addition, Medicaid provider agreements stated that "payment" constitutes payment in full for any covered services and a covered provider agreed not to charge the member or ODM (Medicaid) any co-payment, cost sharing, down payment, or similar charge, refundable or otherwise.

20. Medicaid was a "health care benefit program" as defined in 18 U.S.C. §24(b).

21. RCI was an Ohio Medicaid providers, and as such BRENDA GRIFFITH signed a provider agreement with the Ohio Medicaid program agreeing to the rules and regulations of the program.

IV. CPT CODES

22. Medical providers and health care benefit programs used well-known and standard insurance processing codes to identify certain medical diagnoses and medical treatments and procedures. The American Medical Association assigned and published five-digit codes, known as the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes.

23. Medical providers recorded diagnoses and medical procedures on a standard claim form known in the industry as the CMS 1500 form, which was then sent to the patient's health care benefit program. CPT codes needed to be designated on the CMS 1500 claim form

by the health care provider and then submitted either by mail or electronically to the health care benefit program for payment.

24. Health care claim forms, both paper and electronic, contained certain patient information and treatment billing codes including CPT codes. Health care programs established payment schedules based on the codes billed by the provider. By designating a certain code, the provider certified to the health care program that a given treatment was actually rendered in compliance with the code requirements and was medically necessary. These treatment billing codes were well known to the medical community, providers, and health care insurance companies.

25. Specific CPT codes were assigned for evaluation and management (E/M) services provided to establish patients in a physician's office (some of the E/M services were known as "office visits"). Among these E/M services were office visits billed under CPT codes "99211," "99212," "99213," "99214," and "99215." Insurance companies reimbursed health care providers at increasing rates based upon the level of complexity indicated by the office visit codes.

26. Specific CPT codes were assigned for counseling services. Among these CPT 90837 was utilized by health care providers for the purposes of identifying sixty (60) minutes of individual psychotherapy. Psychotherapy was the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. For a provider to properly bill 90837, they must meet face-to-face with the patient, individually, for sixty minutes. Likewise, health care providers utilized H0004 for behavioral health counseling and therapy when provided for alcohol and/or drug services. Behavioral health counseling and

therapy billed under this code was for individual counseling by a qualified health care clinician for a patient in a private setting, and billed in 15 minute increments. Providers could utilize H0005 to bill for behavioral health counseling and therapy when provided for alcohol and/or drug services. Behavioral health counseling and therapy billed under this code was for group counseling by a qualified health care clinician for a patient, and billed in 15 minute increments.

27. The procedures and services represented by CPT codes were health care benefits, items, and services, within the meaning of Title 18, Section 24(b), United States Code.

COUNT 1
(Conspiracy to Distribute and Dispense a Controlled Substance)

28. Paragraphs 1 through 27 are realleged and incorporated by reference as though fully set forth herein.

29. On or about June 3, 2016, in the Southern District of Ohio, Defendant BRENDA GRIFFITH, did knowingly and willfully combine, conspire, confederate and agree with others, both known and unknown to the United States Attorney, to violate 21 U.S.C. §841(a)(l) and §(b)(l)(E)(i) and that is, to knowingly, intentionally, and unlawfully cause the distribution and dispensing of a mixture and substance containing a detectable amount of buprenorphine and naloxone (namely Suboxone), a schedule III controlled substance, outside the usual scope of professional practice and without a legitimate medical purpose.

In violation of 21 U.S.C. §§846 and 841(a)(1) and (b)(1)(C)

COUNT 2
(Health Care Fraud)

30. Paragraphs 1 through 27 are realleged and incorporated by reference as though fully set forth herein.

31. On or about November 15, 2012, through on or about December 31, 2016, in the Southern District of Ohio, Defendant BRENDA GRIFFITH did knowingly and willfully execute and attempt to execute a scheme and artifice to defraud a health care benefit program, as defined in Title 18, United States Code, Section 24(b), and to obtain by means of false and fraudulent pretenses, representations, and promises, money and property owned by and under the custody and control of said health care benefit programs, in connection with the delivery of and payment for health care benefits, items, and services by causing bills to be submitted to Medicaid for services not rendered.

Execution of the Scheme

32. It was part of the scheme to defraud that BRENDA GRIFFITH through RCI billed or caused the submission of bills to Medicaid and MCOs for counseling services not rendered.

33. Specifically, RCI caused the submission of a false claim to Ohio Medicaid for counseling services allegedly provided to patient DD on or about December 9, 2015, and which claim was billed by RCI on January 30, 2016 in the amount of $280.00. The claim was paid by Medicaid on February 10, 2016 in the amount of $174.56. Patient DD was an undercover agent and the visit was recorded. DD had minimal interaction with the doctor, and received no counseling. In addition, it was later determined her patient file had been altered to make it appear as if she had Suboxone in her system, when she utilized synthetic urine that is clean for all drugs. If Medicaid had known, they would not have paid the false claim.

34. It was further a part of the scheme to defraud that BRENDA GRIFFITH through RCI billed or caused the submission of bills to Medicaid and MCOs, including CareSource,

Buckeye, and Molina, for office visits, while also accepting cash payments from payments for the same office visits.

35. It was further a part of the scheme to defraud that RCI billed or caused the submission of bills to Medicaid and MCOs, for individual counseling sessions when those sessions were provided in a group setting, resulting in a higher payment.

36. It was further a part of the scheme to defraud that from November 15, 2012, through on or about December 31, 2016, BRENDA GRIFFITH through RCI caused the submission of $205,430.56 in fraudulent claims to Ohio Medicaid.

In violation of 18 U.S.C. §1347.

DAVID M. DEVILLERS
UNITED STATES ATTORNEY

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