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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

UNITED STATES OF AMERICA

v.

Case: 2:20-cr-20453
Judge: Berg, Terrence G.
MJ: Patti, Anthony P.
Filed: 09-23-2020 At 11:49 AM
INDI USA V. SEALED MATTER (DA)

D-1 DESTINY ARRINGTON
D-2 EBONY HARVEY-JACKSON,

VIO: 18 U.S.C. § 1349
18 U.S.C. § 1347
18 U.S.C. § 2

Defendants.
_____/

INDICTMENT

THE GRAND JURY CHARGES:

GENERAL ALLEGATIONS

At all times relevant to this Indictment:

The Medicare Program

1. The Medicare program ("Medicare") was a federal health care program providing benefits to persons who were the age of 65 years, or older, or disabled. Medicare was administered by the Centers for Medicare and Medicaid Services ("CMS"), a federal agency under the United States Department of Health and Human Services. The benefits available under Medicare were governed by federal statutes and regulations. Individuals who received benefits under Medicare were referred to as Medicare "beneficiaries."

2. Medicare was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b), and a "Federal health care program," as defined by Title 42, United States Code, Section 1320a-7b(f).

3. Medicare was divided into four parts which helped cover specific services: hospital insurance (Part A), medical insurance (Part B), Medicare Advantage (Part C), and prescription drug benefits (Part D).

4. Specifically, Part B covered medically necessary outpatient individual and group psychotherapy.

5. CMS contracted with various companies to receive, adjudicate, process, and pay Part B claims, including claims for provider services, including psychotherapy. Wisconsin Physicians Service ("WPS") was the CMS contracted carrier for Medicare Part B in the state of Michigan. AdvanceMed was the Zone Program Integrity Contractor ("ZPIC") in the state of Michigan for Medicare from May 2015 until January 2020. Coventbridge (USA) Inc. is currently the ZPIC in Michigan. The ZPIC was the contractor charged with investigating fraud, waste and abuse.

6. Physicians, clinics, and other health care providers that provided services to Medicare beneficiaries were able to apply for and obtain a Medicare "provider number." A health care provider who was issued a Medicare provider number was able to file claims with Medicare to provide reimbursement for

services provided to beneficiaries. A Medicare claim was required to set forth, among other things, the beneficiary's name, the date the services were provided, the cost of the services, and the name and identification number of the physician or other health care provider who had provided the services.

7. By becoming a participating provider in Medicare, enrolled providers agreed to abide by the policies and procedures, rules, and regulations governing reimbursement. In order to receive Medicare funds, enrolled providers, together with their authorized agents, employees, and contractors, were required to abide by all the provisions of the Social Security Act, the regulations promulgated under the Act, and applicable policies, procedures, rules, and regulations issued by CMS and its authorized agents and contractors.

8. Health care providers were given, and provided with online access to, Medicare manuals and services bulletins describing proper billing procedures and billing rules and regulations.

9. Medicare Part B regulations required health care providers enrolled with Medicare to maintain complete and accurate medical records reflecting the medical assessment and diagnoses of their patients, as well as records documenting actual treatment of the patients to whom services were provided and for whom claims for payment were submitted by the physician. These records were required to be sufficient to permit Medicare, through WPS and other contractors, to review

the appropriateness of Medicare payments made to the health care provider under the Part B program.

10. Providers were allowed to submit claims to Medicare for services that they provided and that were medically necessary.

11. Medicare only covered services that were both medically necessary and provided as represented.

12. An electronic funds transfer, or EFT, was the electronic message used by health plans to order a financial institution to electronically transfer funds to a provider's account to pay for health care services. An EFT included information such as: amount being paid, name and identification of the payer and payee, bank accounts of the payer and payee, routing numbers, and date of payment.

13. Medicare permitted the following health care providers to bill for mental health services, including group and individual psychotherapy: qualified physicians; clinical psychologists; clinical social workers (CSWs); nurse practitioners; clinical nurse specialists; and physician assistants.

14. Local Coverage Determinations (LCDs), as defined by the Social Security Act, were decisions made by a Medicare Administrative Contractor (MAC) on whether a particular service or item was reasonable and necessary, and therefore covered by Medicare within the specific region that the MAC oversaw. LCDs 34616 and 30489 were titled "Psychiatry and Psychological Services" and

applied to the primary geographical jurisdiction of Michigan. These LCDs specified that Medicare coverage of psychotherapy did not include teaching grooming skills, monitoring activities of daily living (ADL), recreational therapy (dance, art, play), or social interaction. It also did not include oversight activities such as house or financial management. LCD A54829, entitled "Clinical Social Worker Services," stated that services furnished as an "incident to" CSW personal professional services were not covered.

15. Medicare regulations required health care providers enrolled with Medicare to maintain complete and accurate patient medical records reflecting the medical assessment and diagnoses of their patients, as well as records documenting actual treatment of the patients to whom services were provided and for whom claims for payment were submitted by the physician. Medicare required complete and accurate patient medical records so that Medicare could verify that the services were provided as described on the claim form. These records were required to be sufficient to permit Medicare, through WPS and other contractors, to review the appropriateness of Medicare payments made to the health care provider.

16. Under Medicare Part B, outpatient individual psychotherapy, and outpatient group psychotherapy, were required to be reasonable and medically necessary for the treatment or diagnosis of the patient's illness or injury. Individuals providing these services were required to have the appropriate training,

qualifications, and licenses to provide such services. Providers were required to: (1) document the medical necessity of these services; (2) document the date the service was performed; (3) identify the provider who performed the service; and (4) identify the clinic, physician office, or group practice where the provider provided the service. Providers conveyed this information to Medicare by submitting claims using billing codes and modifiers. To be reimbursed from Medicare for outpatient individual psychotherapy and outpatient group psychotherapy, the services had to be reasonable, medically necessary, documented, and actually provided as represented to Medicare.

17. To receive reimbursement for a covered service from Medicare, a provider was required to submit a claim, either electronically or using a form (*e.g.*, a CMS-1500 form or UB-92), containing the required information appropriately identifying the provider, patient, and services rendered, among other things.

The Peaceful Hearts Practices

18. Peaceful Hearts Adult Day Treatment, LLC ("Peaceful Hearts 1") was a Michigan limited liability company doing business at 10541 Puritan Road, Detroit, Michigan. Peaceful Hearts 1 was enrolled as a participating provider with Medicare on or about April 4, 2017 and submitted claims to Medicare.

19. Peaceful Hearts Adult Day Care 2 ("Peaceful Hearts 2") (referred to collectively with Peaceful Hearts 1 as the "Peaceful Hearts Practices") was a Michigan limited liability company doing business at 19115 W 7 Mile Road, Detroit, Michigan. Peaceful Hearts 2 was enrolled as a participating provider with Medicare on or about October 22, 2018 and submitted claims to Medicare.

Defendants and Other Individuals

20. Defendant **DESTINY ARRINGTON**, a resident of Oakland County, Michigan, was a co-owner of Peaceful Hearts 2 with **EBONY HARVEY-JACKSON**, and sole owner of Peaceful Hearts 1.

21. Defendant **EBONY HARVEY-JACKSON**, a resident of Wayne County, Michigan, was a Master's Level Social Worker with an active license, who was enrolled as a participating provider with Medicare. **HARVEY-JACKSON** was co-owner of Peaceful Hearts 2 with **DESTINY ARRINGTON**. **HARVEY-JACKSON** worked as the managing social worker at both Peaceful Hearts Practices and claims were submitted to Medicare for psychotherapy services purportedly provided by **HARVEY-JACKSON** at both Peaceful Hearts Practices.

COUNT 1
(18 U.S.C. § 1349—Conspiracy to Commit Health Care Fraud)
D-1 DESTINY ARRINGTON
D-2 EBONY HARVEY-JACKSON

22. Paragraphs 1 through 21 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

23. From in or around April 2017, and continuing through the present, the exact dates being unknown to the Grand Jury, in Wayne County, in the Eastern District of Michigan, and elsewhere, **DESTINY ARRINGTON** and **EBONY HARVEY-JACKSON** did willfully and knowingly combine, conspire, confederate, and agree with each other, and others known and unknown to the Grand Jury, to commit certain offenses against the United States, namely: to knowingly and willfully execute a scheme and artifice to defraud a health care

benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), that is, Medicare, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, said health care benefit program, in connection with the delivery of and payment for health care benefits, items, and services, in violation of Title 18, United States Code, Section 1347.

Purpose of the Conspiracy

24. It was a purpose of the conspiracy for the defendants and their co-conspirators to unlawfully enrich themselves by, among other things: (a) submitting and causing the submission of false and fraudulent claims to Medicare for services that were (i) medically unnecessary, (ii) not eligible for reimbursement, and (iii) not provided as represented; (b) concealing the submission of false and fraudulent claims to Medicare, and the receipt and transfer of the proceeds from the fraud; and (c) diverting proceeds of the fraud for the personal use and benefit of the defendants and their co-conspirators.

Manner and Means

25. The manner and means by which the defendants and their co-conspirators sought to accomplish the purpose of the conspiracy included, among others, the following:

26. **ARRINGTON** organized Peaceful Hearts 1 as limited liability company in Michigan on or about February 3, 2017.

27. **ARRINGTON** applied to enroll Peaceful Hearts 1 as a participating provider with Medicare and Peaceful Hearts 1 became a Medicare provider on or about April 4, 2017.

28. **HARVEY-JACKSON** reassigned her National Provider Identification number to Peaceful Hearts 1 on or about April 5, 2017, which allowed Peaceful Hearts 1 to submit claims to Medicare for services provided by **HARVEY-JACKSON**.

29. On or about May 4, 2017, **ARRINGTON** certified to Medicare that Peaceful Hearts 1 would comply with all Medicare rules and regulations, including that she would not knowingly present or cause to be presented a false and fraudulent claim for payment by Medicare. ARRINGTON repeatedly re-certified that she would abide by Medicare's rules, regulations, and laws, including in 2019 and 2020.

30. **ARRINGTON** and **HARVEY-JACKSON** organized Peaceful Hearts 2 as a limited liability company in Michigan on or about July 19, 2018.

30. **HARVEY-JACKSON** applied to enroll Peaceful Hearts 2 as a participating provider with Medicare and Peaceful Hearts 2 became a Medicare provider on or about October 22, 2018.

31. **HARVEY-JACKSON** reassigned her National Provider Identification number to Peaceful Hearts 2 on or about October 22, 2018, which allowed Peaceful Hearts 2 to submit claims to Medicare for services provided by **HARVEY-JACKSON**.

32. On or about November 21, 2018, **HARVEY-JACKSON** certified to Medicare that Peaceful Hearts 2 would comply with all Medicare rules and regulations, including that she would not knowingly present or cause to be presented a false and fraudulent claim for payment by Medicare. **HARVEY-JACKSON** repeatedly re-certified that she would abide by Medicare's rules, regulations, and laws, including in December 2018 and several times in 2019.

33. **ARRINGTON**, **HARVEY-JACKSON**, and others submitted, and caused the submission of, claims to Medicare for psychotherapy services, when in fact the beneficiaries did not receive psychotherapy and instead, they participated in social activities such as watching movies, playing games, and exercising.

34. **ARRINGTON**, **HARVEY-JACKSON**, and others submitted, and caused the submission of, claims to Medicare for psychotherapy services, when in fact the beneficiaries were not present at the Peaceful Hearts Practices and did not receive any psychotherapy.

35. **ARRINGTON**, **HARVEY-JACKSON**, and others submitted, and caused the submission of, claims to Medicare for psychotherapy services that were

provided by individuals who were not properly licensed and who were not authorized providers with Medicare to provide such services.

36. **ARRINGTON**, **HARVEY-JACKSON**, and others submitted, and caused the submission of, approximately $2,216,060 in false and fraudulent claims to Medicare for psychotherapy services purportedly provided at Peaceful Hearts 1 that were medically unnecessary, not provided as represented, and not otherwise eligible for reimbursement.

37. **ARRINGTON**, **HARVEY-JACKSON**, and others submitted, and caused the submission of, approximately $756,780 in false and fraudulent claims to Medicare for psychotherapy services purportedly provided at Peaceful Hearts 2 that were medically unnecessary, not provided as represented, and not otherwise eligible for reimbursement.

38. **ARRINGTON**, **HARVEY-JACKSON**, and others caused the transfer and disbursement of illicit proceeds derived from the fraudulent scheme to themselves and others.

COUNTS 2-5
(18 U.S.C. §§ 1347 and 2 – Health Care Fraud)
D-1 DESTINY ARRINGTON
D-2 EBONY HARVEY-JACKSON

39. Paragraphs 1 through 21 of General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

40. On or about the dates enumerated below, in Wayne County, in the Eastern District of Michigan, and elsewhere, **ARRINGTON and HARVEY-JACKSON**, in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud a health care benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), that is, Medicare, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by and under the custody and control of Medicare in connection with the delivery of and payment for health care benefits, items, and services.

Purpose of the Scheme and Artifice

41. It was the purpose of the scheme and artifice for **ARRINGTON and HARVEY-JACKSON** to unlawfully enrich themselves and their accomplices by, among other things: (a) submitting and causing the submission of false and fraudulent claims to Medicare for services that were (i) medically unnecessary, (ii) not provided as represented, or (iii) not otherwise eligible for reimbursement; (b) concealing the submission of false and fraudulent claims to Medicare, and the receipt and transfer of the proceeds from the fraud; and (c) diverting proceeds of the fraud for the personal use and benefit of the defendants and their accomplices.

The Scheme and Artifice

42. Paragraphs 25 through 36 of this Indictment are re-alleged and incorporated by reference as though fully set forth herein as a description of the scheme and artifice.

Acts in Execution of the Scheme and Artifice

43. On or about the dates specified below, in Wayne County, in the Eastern District of Michigan, and elsewhere, **ARRINGTON and HARVEY-JACKSON**, in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, the above-described scheme and artifice to defraud a health care benefit program affecting commerce, that is, Medicare, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of said health care benefit program:

Count 2	J.C.	12/26/2018	1/2/2019	CPT 90834 Individual Psychotherapy	$100
Count 3	J.C.	12/26/2018	1/2/2019	CPT 90853 Group Psychotherapy	$45
Count 4	O.G.	12/26/2019	12/30/2019	CPT 90834 Individual Psychotherapy	$100
Count 5	O.G.	12/26/2019	12/30/2019	CPT 90853 Group Psychotherapy	$45

In violation of Title 18, United States Code, Sections 1347 and 2.

FORFEITURE ALLEGATIONS
(18 U.S.C. § 981(a)(1)(C) and 28 U.S.C. § 2461(c); 18 U.S.C. § 982(a)(7)—Criminal Forfeiture)

44. The above allegations contained in this Indictment are incorporated by reference as if set forth fully herein for the purpose of alleging forfeiture pursuant to the provisions of Title 18, United States Code, Sections 981(a)(1)(C) and 982(a)(7), and Title 28, United States Code, Section 2461(c).

45. Pursuant to Title 18, United States Code, Section 982(a)(7), upon being convicted of the crime charged in Count 1 of this Indictment, the convicted defendants shall forfeit to the United States any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

46. Pursuant to Title 18, United States Code, Section 981(a)(1)(C), together with Title 28, United States Code, Section 2461(c), upon being convicted of the crimes charged in Counts 2 through 5 of this Indictment, the convicted defendants shall forfeit to the United States any property, real or personal, which constitutes or is derived from proceeds traceable to the commission of the offense(s).

47. Such property includes, but is not limited to:

- $80,783.11 in funds from Bank of America Account No. 375020413205 held in the name of Peaceful Hearts Adult Daycare 2 LLC;
- $4,871.00 in funds from Bank of America Account No. 375015524918 held in the name of Peaceful Hearts Adult Day Treatment LLC; and
- $14,698.43 in funds from Bank of America Account No. 375020413195 held in the name of Peaceful Hearts Adult Daycare 2 LLC.

48. Money Judgment: Such property includes, but is not limited to, a forfeiture money judgment against **ARRINGTON** and **HARVEY-JACKSON** in an amount to be determined, representing the total value of all property subject to forfeiture as a result of their violation(s) of 18 U.S.C. § 1349, as alleged in Count 1, and 18 U.S.C. § 1347, as alleged in Counts 2 through 5 of this Indictment.

49. Substitute Assets: If the property described above as being subject to forfeiture, as a result of any act or omission of the defendant:

a) cannot be located upon the exercise of due diligence;

b) has been transferred or sold to, or deposited with, a third party;

c) has been placed beyond the jurisdiction of the Court;

d) has been substantially diminished in value; or

e) has been commingled with other property that cannot be subdivided without difficulty;

it is the intent of the United States, pursuant to 21 U.S.C. § 853(p) as incorporated by 18 U.S.C. § 982(b) and 28 U.S.C. § 2461(c), to seek to forfeit any other property of the defendant up to the value of the forfeitable property described above.

THIS IS A TRUE BILL.

s/Grand Jury Foreperson
Grand Jury Foreperson

MATTHEW SCHNEIDER
UNITED STATES ATTORNEY

DANIEL KAHN
ACTING CHIEF, FRAUD SECTION
CRIMINAL DIVISION
U.S. DEPARTMENT OF JUSTICE

REGINA R. MCCULLOUGH
Chief, Health Care Fraud Unit
Assistant United States Attorney

MALISA DUBAL
Assistant Chief, Fraud Section
U.S. Department of Justice

s/Steven Scott
STEVEN SCOTT
KATHLEEN COOPERSTEIN
Trial Attorneys
Criminal Division, Fraud Section
U.S. Department of Justice
1400 New York Avenue, N.W.,
Washington, D.C. 20005
(202) 262-6763
Steven.scott@usdoj.gov

Dated: September 23, 2020

United States District Court Eastern District of Michigan	**Criminal Case Cove**

Case: 2:20-cr-20453
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NOTE: It is the responsibility of the Assistant U.S. Attorney signing this form to complete it accurately in all respects.

Companion Case Information	**Companion Case Number:**
This may be a companion case based upon **LCrR 57.10 (b)(4)**[1]**:**	**Judge Assigned:**
☐ **Yes** ☒ **No**	**AUSA's Initials:** SS

Case Title: USA v. DESTINY ARRINGTON, ET AL

County where offense occurred : Wayne County

Check One: ☒**Felony** ☐**Misdemeanor** ☐**Petty**

✓ Indictment/____Information --- **no** prior complaint.
____Indictment/____Information --- based upon prior complaint [**Case number:**]
____Indictment/____Information --- based upon **LCrR 57.10 (d)** ***[Complete Superseding section below]***.

Superseding Case Information

Superseding to Case No: _____ **Judge:** _____

☐ Corrects errors; no additional charges or defendants.
☐ Involves, for plea purposes, different charges or adds counts.
☐ Embraces same subject matter but adds the additional defendants or charges below:

Defendant name	**Charges**	**Prior Complaint (if applicable)**

Please take notice that the below listed Assistant United States Attorney is the attorney of record for the above captioned case.

September 23, 2020
Date

Steven Scott, Trial Attorney
211 West Fort Street, Detroit, MI 48226
Phone: (202) 262-6763
Fax: (313) 226-0816
E-Mail address: Steven.Scott@usdoj.gov
Attorney Bar #: IL 6306957

[1] Companion cases are matters in which it appears that (1) substantially similar evidence will be offered at trial, or (2) the same or related parties are present, and the cases arise out of the same transaction or occurrence. Cases may be companion cases even though one of them may have already been terminated.