UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

UNITED STATES OF AMERICA	CRIMINAL NO. 3:24CR125 (KAD)
v.	VIOLATION:
SHAWN TYSON	18 U.S.C. § 1347 (Health Care Fraud)

INFORMATION

The United States Attorney charges:

COUNT ONE
(Health Care Fraud)

Background

At all times relevant to this Information:

1. The defendant, SHAWN TYSON ("TYSON"), worked as a Licensed Alcohol and Drug Abuse Counselor (LADC) in the State of Connecticut. In this capacity, TYSON offered substance abuse treatment and related counseling services to patients.

2. The Connecticut Medicaid program (or "Medicaid") was a "health care benefit program," as defined under Title 18, United States Code, Section 24(b), in which medical benefits, items and services were provided to Medicaid members in Connecticut. The Connecticut Medicaid program was jointly funded by the State of Connecticut and the United States. In Connecticut, the Department of Social Services ("DSS") administered the Medicaid program.

3. In November 2019, TYSON filed his initial enrollment application to participate as a provider in the Medicaid program. TYSON subsequently became a participating provider in the Medicaid program, and was issued a unique Medicaid provider number. According to Medicaid records, TYSON's office was located at 330 Main Street in Hartford.

4. The Connecticut DSS Provider Manual, which set forth the rules of the Medicaid

program, defined "behavioral health clinician services" as "preventive, diagnostic, therapeutic, rehabilitative or palliative services provided by a licensed behavioral health clinician within the licensed behavioral health clinician's scope of practice under state law."

5. Pursuant to Section 17b-262-916 of Chapter 7 of the Connecticut DSS Provider Manual, Medicaid paid providers "only for behavioral health clinician services that are: (1) Within the licensed behavioral health clinician's scope of practice as defined by chapters 376b, 383a, 383b, or 383c of the Connecticut General Statutes, as applicable to the behavioral health clinician; and (2) medically necessary to treat the client's condition." The provider manual also stated that Medicaid does not pay for "services provided by anyone other than" the licensed provider.

6. In order to participate in the Medicaid program, health care providers completed enrollment forms and provided proof of licensure. As part of their enrollment, providers certified that they would abide by all applicable federal and state statutes and regulations and would keep accurate and current records regarding the nature, scope, and extent of services furnished to Medicaid recipients. They also acknowledged prohibitions against the following:

a) false statements, misrepresentation, concealment, failure to disclose, and conversion of benefits;

b) any giving or seeking of kickbacks, rebates, or similar remuneration;

c) charging or receiving reimbursement in excess of that provided by the State; and

d) false statements or misrepresentation in order to qualify as a provider.

7. Participating providers typically submitted claims to Medicaid electronically, using Medicaid's online billing portal. A provider signed into the portal using the provider's unique username and password, and then submitted claim information for each service provided to Medicaid members. This information included the name and provider number of the provider who

rendered the service; the name and Medicaid number of the Medicaid patient who received the service; the date the service was performed; a code delineating where the service was provided; the procedure code for the service that was rendered; and the diagnosis of the patient's condition for which the service was rendered.

The Scheme and Artifice to Defraud Medicaid

8. Beginning in at least November 2019 and ending in or about April 2023, TYSON, together with an individual identified herein as Provider 1, whose identity is known to the United States Attorney, knowingly, willfully, and with the specific intent to defraud, executed and attempted to execute a scheme and artifice to defraud Medicaid and to obtain money and property owned by and under the custody and control of Medicaid by means of false and fraudulent pretenses, representations, and promises, in connection with the delivery of and payment for health care benefits, items, and services.

9. The purpose of the scheme and artifice was to enrich TYSON and Provider 1 by submitting materially false and fraudulent claims to Medicaid and receiving payments from Medicaid for those claims.

Manner and Means

10. It was part of the scheme and artifice that TYSON took the following steps, among others, in the District of Connecticut and elsewhere.

11. From approximately December 2019 to approximately February 2023, TYSON submitted and caused to be submitted under his own Medicaid provider number false and fraudulent claims for payment for psychotherapy and related services that Provider 1 had purportedly provided to particular patients. The claims TYSON submitted and caused to be

submitted falsely represented that TYSON had personally rendered the services, when as TYSON well and truly knew, he had not provided the services.

12. From approximately December 2019 to approximately February 2023, TYSON submitted and caused to be submitted false and fraudulent claims for payment from Medicaid for services that were not provided, knowing at the time the claims were made that they were false and fraudulent. These claims included claims for services for individuals who were no longer patients of TYSON; claims for services on dates when TYSON did not, in fact, see the patients; claims for services allegedly rendered when TYSON was employed full-time elsewhere; and claims for services TYSON purportedly provided in the State of Connecticut when in fact TYSON was traveling outside the State on the date the service was rendered.

13. In order to conceal the scheme and artifice, from in or about October 2022 to in or about November 2022, in response to a Medicaid audit, TYSON submitted and caused to be submitted to the DSS false and fraudulent documents which TYSON represented to be patient records, including treatment plans and progress notes purportedly created at the time the services were provided. In fact, those records were created by TYSON after he received the audit demand.

Execution of the Scheme and Artifice

14. On or about September 24, 2022, in order to knowingly and willfully execute the scheme and artifice, SHAWN TYSON submitted and caused to be submitted to Medicaid a materially false and fraudulent claim which represented that on or about September 22, 2022, TYSON had personally rendered a 60-minute psychotherapy session to a patient whose identity is known to the United States Attorney and whose initials are R.C., when, as TYSON knew, TYSON had not provided any such service to R.C. on that date.

All in violation of Title 18, United States Code, Section 1347.

UNITED STATES OF AMERICA

VANESSA ROBERTS AVERY
UNITED STATES ATTORNEY

DAVID J. SHELDON
ASSISTANT UNITED STATES ATTORNEY