Department of Justice

U.S. Attorney's Office

Northern District of Texas

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Last Defendant Sentenced in Health Care Fraud Scheme

DALLAS — Cynthia Stiger, 52, of Dallas, Texas, who was convicted in April 2016 of one count of conspiracy to commit health care fraud, was sentenced yesterday by U.S. District Judge Sam A. Lindsay to 120 months in federal prison and ordered to pay $23,630,777.26 in restitution, joint and several with all codefendants to Medicare and Medicaid, announced U.S. Attorney John Parker of the Northern District of Texas.

Judge Lindsay ordered Stiger to report to the Bureau of Prisons on November 28, 2017.

"This office will continue to use the most sophisticated techniques available to aggressively prosecute those who, through their fraud, drive up the costs of health care to consumers and tax payers alike," said U.S. Attorney Parker. "I applaud the tremendous cooperation among the investigative agencies that brought us to this point."

The following defendants have also been sentenced for their role in the health care fraud scheme:

Jacques Roy, 420 months and $268,147,699.15 in restitution
Wilbert James Veasey, Jr., 120 months and $23 million in restitution
Cyprian Akamnonu, 120 months and $25 million in restitution
Patricia Akamnonu, 120 months and $25 million in restitution
Charity Eleda, 48 months and $397,294.51 in restitution
Teri Sivils, 3 years probation and $885,714.05 in restitution

The government presented evidence at trial that Dr. Roy, Stiger, Veasey and Eleda engaged in a large-scale, sophisticated health care fraud scheme in which they conspired together and with others to defraud Medicare and Medicaid through companies they owned/controlled: Medistat

Group Associates, P.A., Apple of Your Eye Health Care Services, Inc., Ultimate Care Home Health Services and Charry Home Care Services.

As part of the conspiracy, Stiger, Veasey and Eleda, along with others, improperly recruited individuals with Medicare coverage to sign up for Medicare home health care services. Eleda recruited patients from The Bridge homeless shelter in Dallas, sometimes paying recruiters $50 per beneficiary they found and directed to her vehicle parked outside the shelter's gates. Eleda and other nurses would falsify medical documents to make it appear as though those beneficiaries qualified for home health care services that were not medically necessary. Eleda and the nurses prepared Plans of Care (POC), also known as 485's, which were not medically necessary, and these POCs were delivered to Dr. Roy's office and not properly reviewed by any physician.

Dr. Roy instructed his staff to certify these POCs, which indicated to Medicare and Medicaid that a doctor, typically Dr. Roy, had reviewed the treatment plan and deemed it medically necessary. That certifying doctor, typically Dr. Roy, certified that the patient required home health services, which were only permitted to be provided to those individuals who were homebound and required, among other things, skilled nursing. This process was repeated for thousands of POCs, and, in fact, Medistat's office included a "485 Department," essentially a "boiler room" to affix fraudulent signatures and certifications.

Once an individual was certified for home health care services, Eleda, nurses who worked for Stiger and Veasey, and other nurses falsified visit notes to make it appear as though skilled nursing services were being provided and continued to be necessary. Dr. Roy would also visit the patients, perform unnecessary home visits, and then order unnecessary medical services for the recruited beneficiaries. Then, at Dr. Roy's instruction, Medistat employees would submit fraudulent claims to Medicare for the certification and recertification of unnecessary home health care services and other unnecessary medical services.

The government presented further evidence at trial that the scope of Dr. Roy's fraud was massive; Medistat processed and approved POCs for 11,000 unique Medicare beneficiaries from more than 500 different home health agencies. Dr. Roy entered into formal and informal fraudulent arrangements with Apple, Charry, Ultimate and other home health agencies to ensure his fraudulent business model worked and that he maintained a steady stream of Medicare beneficiaries.

The case was investigated by the Federal Bureau of Investigation, the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG), and the Texas Attorney General's Medicaid Fraud Control Unit (MFCU) and was brought as part of the Medicare Fraud Strike Force supervised by the Criminal Division Fraud Section and the U.S. Attorney's Office for the Northern District of Texas.

Assistant U.S. Attorneys P.J. Meitl and Nicole Dana and First Assistant U.S. Attorney Chad Meacham prosecuted the case.

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Topic(s):
Healthcare Fraud

Component(s):
USAO - Texas, Northern

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