Final Order No. DOH-02-1288-FOT-MQA
FILED DATE - 8/26/02
Department of Health
By: Vicki R. Kona
Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

CASE NO.: 2001-09548
LICENSE NO.: ME0041475

JEROME H. FELDMAN, M.D.,

Respondent.

_____/

FINAL ORDER

THIS CAUSE came before the Board of Medicine (Board) pursuant to Sections 120.569 and 120.57(2), Florida Statutes, on August 2, in Orlando, Florida, for consideration of the Administrative Complaint (attached hereto as Exhibit A) in the above-styled cause. Respondent was served with the Administrative Complaint by publication. Because Respondent failed to submit an Election of Rights or otherwise dispute the facts or respond in any other way, this cause was treated as a default. At the hearing, Petitioner was represented by Ephraim Livingston, Senior Prosecuting Attorney. No dispute of material fact has been asserted.

Upon consideration, it is ORDERED:

1. Respondent is found to be in DEFAULT.

2. The allegations of fact set forth in the Administrative Complaint are approved and adopted and incorporated herein by reference as the findings of fact by the Board.

3. The conclusions of law alleged and set forth in the

Administrative Complaint are approved and adopted and incorporated herein by reference as the conclusions of law by the Board.

4. The violations set forth warrant disciplinary action by the Board. THEREFORE,

IT IS HEREBY ORDERED AND ADJUDGED:

Respondent's license to practice medicine in the State of Florida is hereby REVOKED.

This Final Order shall take effect upon being filed with the Clerk of the Department of Health.

DONE AND ORDERED this 22 day of AUGUST, 2002.

BOARD OF MEDICINE

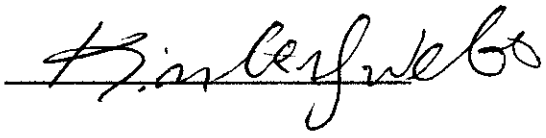
LARRY G. MCPHERSON, JR., EXECUTIVE DIRECTOR
For
ZACHARIAH P. ZACHARIAH, M.D.
CHAIRMAN

NOTICE OF RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW PURSUANT TO SECTION 120.68, FLORIDA STATUTES. REVIEW PROCEEDINGS ARE GOVERNED BY THE FLORIDA RULES OF APPELLATE PROCEDURE. SUCH PROCEEDINGS ARE COMMENCED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF THE DEPARTMENT OF HEALTH AND A SECOND COPY, ACCOMPANIED BY FILING FEES PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL, FIRST DISTRICT, OR WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE PARTY RESIDES. THE NOTICE OF APPEAL MUST BE FILED WITHIN THIRTY (30) DAYS OF RENDITION OF THE ORDER TO BE REVIEWED.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by U.S. Mail to Jerome H. Feldman, M.D., 115 Shady Branch Trail, Ormond Beach, Florida 32174-4930, and 1456 Farrindon Circle, Heathrow, Florida 32746; and by interoffice delivery to Nancy M. Srurkowski, Chief - Practitioner Regulation, and Lisa Pease, Senior Attorney - Appeals, Department of Health, 4052 Bald Cypress Way, Bin #C-65, Tallahassee, Florida 33299-3265, on or before 5:00 p.m., this 26 day of August, 2002.



**STATE OF FLORIDA**
**DEPARTMENT OF HEALTH**

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|---|---|---|
| DEPARTMENT OF HEALTH,<br><br>PETITIONER,<br><br>v.<br><br>JEROME FELDMAN, M.D.,<br><br>RESPONDENT. | ) | CASE NO. 2001-09548 |

## ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, Department of Health, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against Jerome Feldman, M. D., hereinafter referred to as "Respondent" and alleges:

## PARTIES

1. Effective July 1, 1997, Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes, and Chapters 456 and 458, Florida Statutes. Pursuant to the provisions of Section 20.43(3), Florida Statutes, the Petitioner has contracted with the Agency for Health Care Administration to provide consumer complaint, investigative, and prosecutorial services required by the Division of Medical Quality Assurance, councils, or boards, as appropriate.

2. Respondent is and has been at all times material hereto a licensed physician in the state of Florida, having been issued license number ME 0041475. Respondent's last known address is 115 Shady Branch Trail, Ormond Beach, FL 32174.

## GENERAL ALLEGATIONS

3. Jerome Feldman Community Mental Health Center, Inc. ("JFCMHC") is a for profit Florida corporation located at 430 South Orange Blossom Trai, Orlando, Florida, or at 800 West Lake Mary Boulevard, Sanford, Florida.

4. At all relevant times set forth herein, Respondent was the sole owner, incorporator and a director of JFCMHC and operated JFCMHC as a community mental health center ("CMHC").

5. The Department of Health and Human Services ("HHS"), through the Health Care Financing Administration ("HCFA"), administers the Medicare program, a system of health insurance for the aged and disabled. Medicare Part A covers the costs incurred by eligible beneficiaries for certain partial hospitalization services received at community mental health clinics.

6. In administering and supervising the Medicare Program, HCFA contracts with various fiscal intermediaries to process Medicare claims and payments. Blue Cross/Blue Shield of Florida ("BCBSF") and Mutual of Omaha

("Mutual") contract with "HCFA" to receive, process, administer, and pay certain claims submitted for Medicare reimbursement under Part A of the program.

7. In order to obtain reimbursement from Medicare under Part A of the program, a CMHC submits claims to Medicare intermediaries on a standardized form. On this form, the CMHC must state, among other things: (a) the patient's name; (b) the diagnosis; (c) the type and quantity of services provided; (d) the dates of service (that is, the period of time during which the services were provided); and, (e) the name and address of the physician supplying the service and the name and address of the CMHC providing the services for which the claim is being submitted.

8. The CMHC also must file an annual report of its costs called a "Statement of Reimbursable Cost" or "cost report," which is also a claim for payment containing a breakdown of the costs associated with the treatment of eligible Medicare beneficiaries.

9. Upon receiving a claim, the Medicare fiscal intermediary reimburses the CMHC based upon a previously established rate. At year-end, the Medicare fiscal intermediary compares the total interim payments made to the CMHC throughout the year to the total costs reported on the cost report and makes a final settlement to the CMHC.

10. Through HCFA, HHS also administers the Medicaid Program, which provides medical care for the poor, disabled and aged, and which is funded in part from federal funds and in part from state funds.

11. In general, a partial hospitalization program ("PHP") is a comprehensive program that uses a multidisciplinary team to provide comprehensive services within an individual treatment plan to individuals diagnosed with one or more psychiatric disorders. The purpose of a PHP is to treat patients who exhibit severe or disabling conditions related to acute psychiatric and/or psychological conditions or severe or persistent mental disorders. Partial hospitalization occurs in lieu of admission to an inpatient hospital or a continued inpatient hospitalization, and is not appropriate to treat patients who have achieved sufficient stability so that they no longer require intense, frequent therapy.

12. The Medicare program only allows payment for partial hospitalization services:

(a) Prescribed, supervised and evaluated by a physician;

(b) Provided under an individualized, written treatment plan which sets forth (i) the physician's diagnosis; (ii) the type, amount, frequency and duration of the services provided under the plan; and (iii) the goals for treatment under the plan;

(c) Reasonable and necessary for the diagnosis or active treatment of the patient's condition; and

(d) Reasonably expected to improve or maintain the patient's condition and functional level to prevent relapse or hospitalization.

13. For each patient for whom a claim for partial hospitalization services has been made, the Medicare program requires that a physician certify every thirty-one days that:

(a) the beneficiary would require inpatient psychiatric care in the absence of such services;

(b) an individualized plan for furnishing such services has been established by a physician and is reviewed periodically by a physician; and

(c) such services are or were furnished while the individual is or was under the care of a physician.

14. One partial hospitalization service that the Medicare program reimburses is group therapy with psychiatrists, psychologists or other mental health professionals to the extent authorized under state law. In addition to psychiatrists and psychologists, Florida law authorizes licensed clinical social workers and licensed mental health counselors to provide group therapy. Chapter 491, Fla. Stat.

15. The Medicare program reimburses certified CMHC's for the provision of partial hospitalization services. In order to receive certification and participate in the Medicare program, a CMHC must provide all of the following services:

(a) outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill or patients discharged from an inpatient mental health facility;

(b) 24- hour emergency care services;

(c) day treatment or other partial hospitalization services or psychosocial rehabilitation services;

(d) screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and

(e) consultation and education services.

16. The Medicare program reimburses only care that is reasonable and necessary for the treatment or diagnosis of illness or injury. Medicare reimbursement is not permitted for unnecessary or unreasonable care and services.

17. A provider is not permitted reimbursement under the Medicare Program unless adequate documentation exists in the patient's medical file that demonstrates the performance of services and the medical necessity of the services for which reimbursement is claimed by the provider.

18. A CMHC must maintain accurate and current medical records as a condition of participation in the Medicare and Medicaid programs.

19. Medicaid reimburses only group psychotherapy (CPT Code 90853), which is personally performed by a licensed provider.

20. On or about October 8, 1986, Respondent was issued Medicaid provider number 0438308.

21. In or about 1986, Respondent was issued Medicare provider number 02572.

22. On or about December 10, 1994, JFCMHC, through its owner, Respondent, submitted an application to AHCA for review and forwarding to HCFA in which JFCMHC requested certification in the Medicare program as a CMHC provider.

23. On the application for certification as a Medicare provider,

Respondent falsely certified that JFCMHC provided all five services required of a CMHC in order to be certified.

24. Respondent knew that his statement was false because JFCMHC did not provide any of the services of a CMHC.

25. Based upon Respondent's false certification, ACHA certified JFCMHC as a CMHC and issued JFCMHC provider number 104734. Feldman and JFCMHC used the provider number to submit false claims for payment to the Medicare program.

26. From in or about December 1994 through at least June 1997, Respondent and JFCMHC knowingly submitted and/or caused to be submitted at least: (a) 1,776 false and fraudulent claims to Medicare for "group therapy" services; and (b) 5,815 false and fraudulent claims to Medicaid for "group therapy" services provided at JFCMHC.

27. During the aforementioned time, Respondent recruited elderly and poor patients for JFCMHC primarily from assisted-living facilities and private residences.

28. Each morning, a JFCMHC employee in a JFCMHC van transported patients from their residential facilities or home residences to the JFCMHC. The patients, who were insured by Medicare, Medicaid, or both, attended the JFCMHC approximately five days a week. At the conclusion of each day, a JFCMHC van transported the patients back to their residences.

29. From in or about December 1994 through at least June 1997, Respondent operated JFCMHC, in part, at 430 South Orange Blossom Trail, Orlando, Florida 32805. This building was an abandoned warehouse in disrepair with no running water or kitchen facilities.

30. The elderly and poor patients spent an average of six to seven hours a day at JFCMHC.

31. Respondent directed his unlicensed staff to provide one "group therapy" session to the Medicaid patients without regard to medical necessity in order to maximize government reimbursements.

32. Respondent directed his unlicensed staff to provide five "group therapy" sessions to the Medicare patients without regard to medical necessity in order to maximize government reimbursements.

33. Respondent did not provide or attend the group therapy sessions, despite representing on his HCFA claim forms that he was the attending physician. On most occasions, Respondent was not at JFCMHC during the group therapy sessions.

34. The group therapy services were not provided by psychiatrists, psychologists, licensed clinical social workers or licensed mental health counselors.

35. Respondent hired unlicensed individuals to provide the group therapy. Among the individuals who provided the group therapy were Feldman's teenage son, a maintenance man, and the van drivers.

36. Respondent and JFCMHC knew that the therapy was not reimbursable by the Medicare or Medicaid, or acted in reckless disregard of that fact, but nevertheless submitted or caused to be submitted the claims for payment.

37. From in or about December 1994, through June 1997, Respondent and JFCMHC knowingly offered and paid remunerations to the owners of assisted living facilities in exchange for Medicare patient referrals to JFCMHC.

38. From on or about January 1, 1995, through at least June 30, 1997 Respondent and JFCMHC paid the health insurance premiums for Virgie James, an owner of Sunrise Retirement Home ("Sunrise").

39. In exchange for the health insurance premiums being paid by the Respondent, Sunrise referred eight Medicare patients to JFCMHC.

40. Respondent knowingly submitted or caused to be submitted at least 307 false claims for group therapy services allegedly provided to the Medicare patients referred by Sunrise.

41. In 1996, Respondent and JFCMHC made at least two cash payments to Shamrock Retirement Home ("Shamrock").

42. In exchange for the cash payments, Respondent knowingly submitted or caused to be submitted at least 127 false claims for group therapy services allegedly provided to these patients.

43. Respondent and JFCMHC provided the following remunerations to Motts Retirement Home ("Motts") in exchange for Medicare referrals:

(a) from in or about December 1994 through at least 1996, Respondent and JFCMHC employed Johanna V. Lightsey, the daughter of Mary Motts, owner of Motts, to transport patients and perform administrative duties; and

(b) in January of 1997, Respondent and JFCMHC hired Nate Brown, Mary Motts' son, to transport patients and perform administrative duties.

44. In exchange for the remunerations described in Paragraph 43 above, Motts referred eight Medicare patients to JFCMHC.

45. Respondent knowingly submitted, or caused to be submitted, at least 198 false claims for group therapy services allegedly provided to these patients.

46. At all relevant times alleged herein, the patients' attendance at JFCMHC was not medically necessary, reasonable or appropriate because none of the patients suffered from acute, disabling mental conditions. The costs and expenses of treating these patients, therefore, were not reimbursable by the government.

47. Respondent and JFCMHC knew, or recklessly disregarded the fact that, the patients were not eligible for treatment at the JFCMHC, but nevertheless fraudulently and falsely submitted or caused to be submitted false claims for payment to Medicare and Medicaid.

48. At all relevant times alleged herein, the group therapy services provided to JFCMHC patients were not medically necessary, reasonable or appropriate and therefore were not reimbursable by the government. The

services were not medically necessary, reasonable or appropriate for the following reasons:

(a) many of the patients suffered from dementia and Alzheimer's Disease with associated cognitive deficits such as loss of memory, speech and motor and sensory function. These medical conditions are chronic and progressive, and are characterized by extreme confusion, disorientation, forgetfulness, agitation and combativeness. These patients could not have participated effectively in the therapy sessions and could not have been reasonably expected to improve from the therapy sessions;

(b) many patients did not have a mental disorder requiring therapy;

(c) many patients suffered from chronic mental disorders and were not eligible for treatment at a CMHC; and

(d) the therapy sessions were social, recreational and diversionary, rather than of a psychotherapeutic nature.

49. Respondent and JFCMHC knew that the therapy was not medically necessary, or acted in reckless disregard of that fact, but nevertheless fraudulently and falsely submitted or caused to be submitted false claims for payment.

50. From in or about December 1994, through at least June 1997, Respondent and JFCMHC knowingly prepared and caused to be prepared false treatment plans, and daily and weekly progress notes for Medicare patients. Respondent and JFCMHC knowingly falsified the medical documentation in the following ways:

(a) In or about 1995, at Feldman's direction, JFCMHC's unlicensed employees falsely created daily and weekly

progress notes documenting group therapy sessions allegedly provided to patients during the previous six months. Respondent and JFCMHC knowingly submitted or caused to be submitted false claims for these group therapy services to Medicare;

(b) from in or about December 1994 through at least June 1997, JFCMHC's unlicensed employees, at Respondent's direction, falsified patients' progress notes to reflect little or no improvement in the patients' condition. Respondent and JFCMHC knowingly submitted or caused to be submitted false claims for these group therapy services to Medicare;

(c) from in or about December 1994 through at least June 1997, JFCMHC's unlicensed employees, at Respondent's direction and training, falsified patients' progress notes. Respondent and JFCMHC knowingly submitted or caused to be submitted false claims for these group therapy services to Medicare; and

51. From on or about May 1, 1996 through at least October 25, 1996, Respondent and JFCMHC knowingly prepared and caused to be prepared at least 345 false HCFA forms which indicated that Jivan Gohi, M. D., was the attending physician for certain Medicare patients.

52. In fact, Dr. Gohil was no longer an employee of JFCMHC and was not the attending physician for those listed Medicare patients. Respondent knowingly submitted or caused to be submitted the false HCFA forms.

53. In addition to the interim claims for payment identified above, on approximately May 28, 1996 and May 30, 1997, Respondent and JFCMHC knowingly submitted or caused to be submitted false cost reports requesting payment from the Medicare program for the costs and expenses of operating JFCMHC and providing group therapy during the periods December 14, 1994

through December 31, 1995 and January 1, 1996 through December 31, 1996, respectively ("Cost Reports").

54. Each of the Cost Reports provided that:

> Intentional misrepresentation or falsification of any information contained in this cost report is punishable by fine and/or imprisonment under federal law,

and required that the JFCMHC officer certify that:

> I have read the above statement and I have examined the accompanying Outpatient Rehabilitation Provider Cost Report and the Statement of Revenue and Expense provided by Jerome Feldman CMHC ...for the cost reporting period beginning...and ending..." and that to the best of my knowledge and belief it is a true, correct, and complete report prepared from the books and records of the provider in accordance with applicable instructions, as noted.

55. Respondent signed the certifications on both Cost Reports.

56. The Cost Reports delineate the expenses which Feldman and JFCMHC specifically represented to be reimbursable by Medicare.

57. At the time that the Cost Reports were prepared and Respondent executed the certifications, Respondent and JFCMHC knew or recklessly disregarded the fact that none of the costs specifically claimed under Medicare were reimbursable because:

(a) JFCMHC did not provide the five core services of a CMHC required under federal and state law and therefore was not a legitimate CMHC provider;

(b) the group therapy services were not medically necessary, appropriate or reasonable;

(c) the group therapy services were not provided by licensed individuals and thus were not reimbursable under Medicare; and

(d) the Medicare patients were not certified or eligible to receive partial hospitalization services.

58. From in or about December 1994 through at least June 1997, Respondent and JFCMHC knowingly submitted or caused to be submitted 50 false and duplicate claims for group therapy provided to the same patient on the same day under Part A and Part B of the Medicare program.

59. Specifically, Respondent falsely billed Medicare Part B for group therapy services using his individual provider number 02572. Respondent and JFCMHC falsely billed Medicare Part A for the same group therapy services using JFCMHC's provider number 104734.

60. Respondent and JFCMHC made the false claims with actual knowledge of their falsity or with reckless disregard or in deliberate ignorance.

61. From in or about January 1, 1995 through December 31, 1996, Respondent and JFCMHC knowingly submitted or caused to be submitted to Medicaid at least 5,815 false claims for group psychotherapy services (CPT Code 90853) provided at JFCMHC.

62. The claims were false because Respondent did not personally provide the group psychotherapy services even though the forms indicated that he provided the services.

63. Respondent and JFCMHC made the false claims with actual knowledge of their falsity or with reckless disregard or in deliberate ignorance.

64. On or about June 18, 1997, HCFA terminated JFCMHC's Medicare provider number, and suspended payments to Respondent.

65. On or about September 8, 1997, ACHA suspended Respondent's Medicaid provider number.

66. A review of Medicare Part A raw claims data and payment history from First Coast Service Options, Inc., (formerly known as Blue Cross Blue Shield of Florida) for the JFCMHC, Medicare Part A provider number 10-4734, for reimbursement of partial hospitalization services at JFCMHC for the period December 14, 1994 through December 31, 1997, revealed that Respondent filed 1,776 claims with Medicare Part A.

67. First Coast then processed 245 Medicare checks, payable to JFCHC totaling $2,592,234.

68. A review of Medicaid raw claims and payment history from the Medicaid Fraud Control Unit for Respondent for reimbursement of individual psychotherapy services for the period December 14, 1994 through December 31, 1997, revealed that Respondent filed 5, 815 claims with Medicaid. Medicaid in turn processed 62 checks totaling $116,918.

69. The above-described Medicare claims totaling $2,592,234 and Medicaid claims totaling $116,918 are fraudulent and based on false reports filed by Respondent.

70. Based on the foregoing, on or about April 10, 2001, Charles R. Wilson, United States Attorney for the United States District Court, Middle District of Florida, Orlando Division filed a civil complaint to recover damages and civil penalties from Respondent and three medically related companies that he was

the sole owner, incorporator, and director of, in Case Number 97-1434-Civ-Or-22.

71. The complaint alleged that Respondent and his corporations did knowingly present false or fraudulent claims to the United States, he knowingly made, used or caused to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the United States, and he conspired to defraud the United Statutes by getting a false or fraudulent claim allowed or paid in violation of 31 U.S.C. § 3729(a)(1), (2), and (3).

72. The complaint alleged that the above-described actions by Respondent damaged the United States government in the amount of $3.4 million dollars. In addition, the complaint alleged that Respondent committed common law fraud, obtained money by unjust enrichment, and that the United States government had made payments on claims submitted by Respondent and his companies in reliance on the mistaken belief that Respondent had billed Medicare only for services that were properly reimbursable resulting in damage to the United States government. The United States Attorney asked the court for reimbursement for treble the amount of damages to the United States, civil penalties and costs.

73. On or about July 10, 2001, a Judgment was entered against Respondent, the Jerome Feldman Community Mental Health Center, the Bertje Corporation, another corporation solely owned by Respondent, and two other parties. The Judgment was entered in the United States District Court Middle

District of Florida, Orlando Division, in the amount of $46,082,456.00 based on the allegations set out in Paragraph 57 above.

74. In or about 1999, following the initiation of investigation into the Respondent's Medicare and Medicaid billing practices and his treatment of patients, Respondent left his practice, left no forwarding address, and has not responded to subpoenas, summons, or notices filed by either the State of Florida or the United State Attorney's office.

COUNT ONE

75. Petitioner realleges and incorporates paragraphs one through seventy-four, as if fully set forth herein this Count One.

76. Respondent, on innumerable occasions, knowingly filed fabricated, false and misleading documents claiming performed services that had not been performed:

(a) Respondent falsely certified that JFCMHC provided all five services required of a CMHC in order to be certified;

(b) From in or about December 1994 through June 1997, the Respondent and JFCMHC knowingly submitted at least 1,776 false and fraudulent claims to Medicare for "group therapy";

(c) From in or about December 1994 through June 1997, the Respondent and JFCMHC knowingly submitted at least 5,815 false and fraudulent claims to Medicaid for "group therapy" services provided at JFCMHC.

77. Based on the foregoing, Respondent has violated Section 458.331(1)(h), Florida Statutes, by making or filing a report that Respondent knew to be false.

COUNT TWO

78. Petitioner realleges and incorporates paragraphs one through seventy-four, as if fully set forth herein this Count One.

79. Respondent and JFCMHC knowingly offered and paid remunerations to owners of assisted living facilities in exchange for Medicare patient referrals to JFCMHC:

(d) From on or about January 1, 1995 through June 30, 1997, the Respondent and JFCMHC paid the health insurance premiums for Virgie James, the owner of Sunrise Retirement Home and in exchange, Sunrise referred eight Medicare patients to JFCMHC;

(e) In 1996, the Respondent and JFCMHC made at least two cash Payments to Shamrock Retirement Home for the purpose of submitting at least 217 knowingly false claims for group therapy services allegedly provided to Shamrock residents;

(f) Respondent and JFCMHC employed Johanna V. Lightsey, the daughter of Mary Motts, owner of Motts Retirement Home, to transport patient and perform administrative duties and Nate Brown, Mary Motts' son, to transport patients and perform

administrative duties and in exchange, Motts referred eight Medicare patients to JFCMHC.

80. Based on the foregoing, Respondent has violated Section 458.331(1)(i), Florida Statutes, in that he paid or received a commission, bonus, kickback, or rebate or engaged in a split-fee arrangement with a physician, organization, agency, or person, either directly or indirectly, for patients referred to providers of health care goods and services, including, but not limited to, hospitals, nursing homes, clinical laboratories, ambulatory surgical centers, or pharmacies.

COUNT THREE

81. Petitioner realleges and incorporates paragraphs one through seventy-four, as if fully set forth herein this Count One.

82. Respondent made deceptive, untrue and fraudulent representations in that:

(a) At the direction of the Respondent, unlicensed employees at JFCMHC created false daily and weekly progress notes;

(b) At the direction of the Respondent, unlicensed employees at JFCMHC falsified patients' progress notes to reflect little or no improvement in the patients' condition;

(c) Respondent and JFCMHC received $2,592,234 in payment from processed Medicare checks.

83. Based on the foregoing, Respondent has violated Section 458.331(1)(k), Florida Statutes, in that he made deceptive, untrue, or fraudulent representations in or related to the practice of medicine or he employed a trick or scheme in the practice of medicine.

WHEREFORE, the Petitioner respectfully requests the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of the Respondent's license, restriction of the Respondent's practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, the assessment of costs related to the investigation and prosecution of this case as provided for in Section 456.072(4), Florida Statutes, and/or any other relief that the Board deems appropriate.

SIGNED this 3rd day of January, 2002

John O. Agwunobi, M.D., M.B.A.
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