STATE OF CONNECTICUT
ATTORNEY GENERAL GEORGE JEPSEN

June 18, 2015

AG Jepsen Files False Claims Act Complaint Alleging Psychiatrist Knowingly Submitted False Claims to the Connecticut Medicaid Program

Attorney General George Jepsen announced today that he has filed a complaint in Hartford Superior Court under the Connecticut False Claims Act seeking treble damages and other relief stemming from an alleged long-running scheme to submit false claims to the Connecticut Medical Assistance Program (CMAP) from January 2010 through December 2014.

The state's complaint alleges that the co-owners of Brighter Concept, Inc. – Dr. Ashwini Sabnis, a licensed psychiatrist enrolled as a provider in the CMAP, and her husband, Saurav "Sam" Mohanty – participated in an elaborate and illegal scheme that resulted in the submission of false claims for services that were not provided, and claims that were "upcoded" - - billed at a higher reimbursement code than warranted. In addition, the complaint alleges that Sabnis and Mohanty knowingly attempted to conceal from the Department of Social Services (DSS), and the Attorney General, the existence of evidence that would have established the fraud.

"This action is being brought to seek damages, civil penalties and other relief due to a scheme that was perpetrated on a health care program intended to care for our most vulnerable citizens," said Attorney General Jepsen. "Health care providers who accept taxpayer dollars must play by the rules."

According to the complaint, Sabnis and Mohanty illegally submitted false claims for reimbursement while knowingly retaining and concealing the overpayment. The defendants submitted, received and retained reimbursement totaling approximately $768,171 for psychiatric services allegedly provided to CMAP.

Department of Social Services Commissioner Roderick L. Bremby said, “Uprooting and eliminating this type of fraudulent activity requires the constant vigilance of oversight agencies. We greatly appreciate the strong enforcement role of the Attorney General’s Office, along with our federal and state partners in human services and law enforcement. While the great majority of Medicaid-enrolled providers are professional and honest, the exceptions require aggressive action on behalf of the program’s overall integrity and the taxpayers who fund

it."

Sabnis is alleged to have engaged in a systemic practice of knowingly "upcoding" the claims for reimbursement she submitted to the CMAP. For example, as the complaint alleges, Sabnis routinely scheduled her Medicaid patients for 15 or 30 minute appointments. However her appointment records, which were obtained during the investigation, revealed that these appointments were often double, triple and in some cases, quadruple booked. When submitting for reimbursement, the state's lawsuit alleges that Sabnis consistently used a reimbursement code which required her to see the patient for approximately 75 to 80 minutes when, in fact, she saw the patient for as little as 5-10 minutes. The state's complaint identifies 113 days where Sabnis billed the CMAP for more than 24 hours of service.

Sabnis and Mohanty are also alleged to have attempted to conceal from DSS auditors the existence of databases that contained information which would have established evidence that the claims were false. The effort to conceal this information continued even after the Attorney General began his investigation.

The action is being brought under the Connecticut False Claims Act, which allows the state to seek relief including civil penalties, treble damages and the cost of investigation from anyone who knowingly submits false or fraudulent claims under a medical assistance program administered by DSS. DSS administers CMAP, which includes Medicaid and other programs that pay for medical benefits for certain low-income and disabled Connecticut residents.

The Attorney General's investigation was initiated by a referral from the DSS' Office of Quality Assurance, which conducted the initial inquiry of Sabnis' billing conduct.

Today's action is part of a larger effort by the State of Connecticut's Interagency Fraud Task Force, which was created in July 2013 to wage a coordinated and proactive effort to investigate and prosecute healthcare fraud directed at state healthcare and human service programs. The task force includes a number of Connecticut agencies and works with federal counterparts in the U. S. Attorney's Office and the U.S. Health and Human Services, Office of Inspector General – Office of Investigations.

Anyone with knowledge of suspected fraud or abuse in the public healthcare system is asked to contact the Medicaid Fraud Control Unit in the Office of the Chief State's Attorney at 860-258-5986 or by email at conndcj@ct.gov; the Attorney General's Antitrust and Government Program Fraud Department at 860-808-5040 or by email at ag.fraud@ct.gov; or the Department of Social Services fraud reporting hotline at 1-800-842-2155 or online at www.ct.gov/dss/reportingfraud, including an email link at providerfraud.dss@ct.gov.

Assistant Attorneys General Natasha Dye and Michael Cole, chief of the Antitrust and Government Program Fraud Department, Paralegal Holly MacDonald and Investigator Peter Harrington, are assisting the Attorney General with this matter.

Please click here to view this complaint.

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