

First Quarter 2021

The information provided in *The Compass* is purely for informational purposes and each company should analyze and verify their own data and facts before initiating an investigation or taking other action.

- **Member Organization Intelligence**
- **Information-Sharing Updates**
- **Spotlight Articles**
- **Government Liaison Intelligence**
- **SIRIS® Quarterly Statistics**
- **Additional Resources & State Newsletters**
- **Agency Descriptions**

NHCAA Anti-Fraud Initiatives Team

Member Organization or Law Enforcement personnel who need assistance or have questions regarding the SIRIS database, Requests for Investigation Assistance (RIAs), or other information-sharing activities should contact the NHCAA Anti-Fraud Initiatives team. Questions? Contact fraud@nhcaa.org.

MEMBER ORGANIZATION INTELLIGENCE

National

COVID-19 Price Gouging

Price gouging scheme for COVID-19 diagnostic and antibody tests continues to be identified. Under section 3202 of the CARES Act, pre-negotiated rates between insurers and providers apply for the duration of the health emergency. All providers of diagnostic tests must list a cash price on a public website and insurers must either pay the listed cash price for tests provided by non-par providers or can negotiate a lower price with these providers. The HHS Secretary is permitted to impose a fine on non-compliant providers.

Payment analysis revealed that in general, non-par providers were paid at a higher rate and larger range than par providers for the following codes: 86328, 86769, 86426, 87635, U0002, U0003, and U0004. Similar trends were also identified for other lab tests and specimen collection codes used with COVID-19-related diagnoses. These other lab tests billed for codes of infectious agent detection by nucleic acid (DNA or RNA) and include 87502, 87581, 87633, 87798, 87799, and 87801. Specimen collection codes include C9803, G2023, and G2024.

DentaQuest Findings on Anterior Composites FWA Scheme

DentaQuest has identified the following issues related to Lack of Medical Necessity/Services Not Rendered:

- Documentation supports written treatment notes which state:
    - Extensive attrition/erosion is present on anterior teeth due to parafunctional habits, but in many instances, preoperative radiographs support exfoliation is imminent.
    - Treatment is completed for aesthetic purposes.
    - Preventive dental products were used instead of restorative composite material.
    - Notes state the decay is visible radiographically, but decay is not observed on the submitted radiographs.
- Comparison of preoperative and postoperative radiographs support:
    - Restorations are broken down or missing at following recall appointment.
    - No evidence of completed restoration(s) is noticeable.
    - There is no proof to support the preparation of billed teeth.
    - There is no indication of change in the pre-existing restorations on the same surface of billed teeth.
- Preoperative intraoral photographs support:
    - No active decay is visible.
    - Intact pre-existing restorations and/or sealants are still present at the time treatment is diagnosed.
    - Fluorosis and/or visible decalcification (with intact tooth structure) is present with no documented attempt to reverse decalcification with alternative services such as topical fluoride treatments, in office varnish, prescription-level paste or silver diamine fluoride.
    - Instances of altered (usually darkened) photographs are submitted.
- Documentation supports a pattern of placing preventive resin restorations (PRR) on the lingual cingulum of anterior teeth but billing as composite restorations, PRRs are usually not a benefit for anterior teeth.
- In instances wherein decay is rampant:
    - Composite restorative treatment on young children results in poor long-term prognosis.
    - Documentation supports some providers are recommending stainless steel crowns but treating members with composites for provider convenience and/or parent compliance.

Radiographs:



- These are before and after radiographs, the left side is preoperative, and the right side is postoperative.
- This shows that there is no composite material on the surface of the front teeth. The provider billed for anterior composites, but the restorations were not medically necessary and either not rendered or failed.

Photographs:



- These pictures are copies of the same photograph. It is an example of the way photographs are darkened when submitted to make the health of the tooth and decay look worse for medical necessity.
- The photo on the left is what was submitted and the photo on the right is one that was lightened by the investigator back to what most intraoral photographs look like (the mouth is a dark place, and the cameras have bright lights on them).

DentaQuest Findings on Manipulation of Patient X-rays FWA Scheme

DentaQuest's clinical review team uncovered a disturbing scheme in New York. There is believed to be a provider that may be inflicting member harm by performing medically unnecessary crowns.

A large percentage of this provider's submitted radiograph images appear to be manipulated. The radiographs submitted contained photoshopped images that when closely reviewed, allegedly displayed coloring over the tooth surface, to make the tooth appear to be broken and fraudulently support the need for the services performed. This set of allegations was particularly noticeable to internal staff as the poorly photoshopped images allegedly displayed coloring that extended over the white border of the radiograph and even extending across cone cuts. The case was referred to the DentaQuest SIU by one of our dentists who supports the Utilization Management program during the prior approval process.

DentaQuest is in the process of onboarding an AI vendor that will focus on fraudulent, duplicate, manipulated or photoshopped radiographic images.

Footbath Trends

Pharmacy utilization data revealed that combinations of topical anti-infectives, corticosteroids and oral/IV antibiotics were being prescribed in extremely large quantities for use in footbaths. Some 30-day treatment regimens can cost as much as $10,000 based on the specific medications and quantities selected. The indications seem to be mostly for toenail fungus or other foot-based infections, as well as surgical/ulcer wound treatment. A scheme such as this footbath issue impacts health insurance carriers, government-sponsored healthcare programs and their members through fraudulent billing that drives up health care costs.

INFORMATION-SHARING UPDATES

Dentists Billing Evaluation & Management CPT Codes 99212-99215 for a COVID-19 Evaluation

Submitted by Becky Bowman, Investigator, Blue Shield of California Special Investigations Unit

Due to the coronavirus (COVID-19) pandemic, precautions were put in place for healthcare providers to remain open and to help stem the spread of COVID-19, including COVID-19 evaluations prior to an in-person visit with a dental provider to determine whether diagnostic testing would be recommended for a patient. A COVID-19 evaluation is conducted by taking a patient's temperature and answering questions or filling out a form regarding COVID-19 symptoms and possible exposure to COVID-19.

Blue Shield of California (Blue Shield) Special Investigations Unit (SIU) received a member referral alerting SIU that her dental provider submitted a claim to Blue Shield for what she considered a high dollar amount for taking her temperature and filling out a form. The member said this billing was in addition to the billing that was made to her dental insurance for the dental services that were performed.

Through the course of the SIU investigation, it was identified that multiple dental providers had received a training by a medical billing company that advised them not only could they bill for additional services being provided to members, but also the billing company would do it for them. The provider billed $2,029.40 before they were placed on Prepayment Review. There were approximately 15 different dentists in the area that were being assisted by this medical billing company, but we did not have exposure for all of them. In a phone call with one office the office manager confirmed that they were taking patient's temperatures and filling out forms then emailing the information to the billing service.

While reviewing the medical records, it was found that documentation did not support the dentist having performed a full history and physical examination, nor making any medical decisions, which is needed to support the CPT code 99213, which was billed the most for these dentists.

Blue Shield SIU determined that the dental provider being investigated was utilizing the services of the medical billing company, and they were in fact billing evaluation and management codes for the COVID-19 evaluation conducted prior to the dental visit.

To validate appropriate billing, health insurance plans may want to investigate and audit medical records for the evaluation and management CPT codes 99212-99215 billed by dental providers for a COVID-19 evaluation.

DME Scheme

Submitted by Kerry Walker, Sr. Investigator, United Healthcare/Optum

Background: DME Provider came into our system as a new biller in October 2019. Manual review of an entire data set of submitted claims showed this DME provider exhibited patterns of billing nearly all members for the same DME, billing for an oral RX that should not be used by a DME supplier and billing multiple family members on the same day using the same diagnosis codes and CPT codes.

Investigative Findings: Through member interviews, this DME provider was discovered to be billing for services not ordered or rendered, waiver of member financial responsibility, misrepresentation of services or products, double billing, lack of medical necessity, and incentivizing members with Amazon gift cards. All referring providers are chiropractors. Member interviews indicate they were told by their chiropractor everything they received was either covered in full by the insurance company or that it was free. Some members reported that they were called out of the blue by their chiropractor offering them free DME.

Near the end of the investigation two things were discovered. First, was that the owner of this DME company created a new DME with a slight name variation of the original. He then obtained a new TIN and NPI in efforts to get reimbursed for previously denied claims submitted under the old TIN. However, the resubmissions for the same DME months later under the new TIN were for dates of service in which members were never seen. Second, was that in a random sampling of the referring providers, it was discovered one chiropractor in particular works in a sober living facility and is ordering DME for members from this company without knowledge or consent of the members in rehab.

Codes of Concern:

- E0730 (TENS unit) & electrode code (A4555) this electrode CPT code is a cancer replacement electrode and would not be able to be used in the TENS unit being billed.
- E0941(Gravity assisted traction device)
- L0648 (anterior/posterior rigid panel back brace)
- L0180 (cervical collar).

The codes are concerning because several members state that while they did not receive a traction device (E0941) or a neck collar (L0180) of any kind, they did receive something called a Posture Pump Disc Hydrator. Others indicated the name of their back brace was the Aspen Horizon 631 which is a wraparound Velcro back brace not a rigid anterior/posterior back brace as billed (L0648). Members also stated they received a topical bio freeze cream in which we were billed CPT code J8499. J8499 represents an oral RX and bio freeze is an over-the-counter topical cream much like icy hot.

Lessons Learned in the Importance of Due Process and Integration in Administrative Actions

Submitted by Jennifer Dietz, Director, TRICARE Program Integrity Division, U.S. Dept. of Defense, Defense Health Agency

In late 2018, our team began a project in identifying compound (suspect) pharmacies identified for high volumes and billed charges with lack of patient-provider relationship. While compounding prescriptions are covered within our benefit, they must meet the criteria for being medically necessary and prescribed by an authorized provider. Utilizing the data mining techniques developed during partnership with DOJ in prosecuting compound pharmacies and marketers for medical unnecessary or services not provided, our team identified a high volume of pharmacies flagged for similar suspect behavior for pharmacies filling prescriptions that did not have any established provider relationships.

Focusing primarily on the lack of patient-prescriber relationship, claims were identified that failed to have corresponding office visits or medical care from the prescribing physician in the 18 months prior to the prescription being filled. While this technique is a great way to shine a flashlight on potential fraud, solely relying on the data only to identify fraud is insufficient and requires additional indicators and further analysis and review.

Our team learned this lesson the hard way, as our agency instructed our pharmacy benefits manager (PBM) to begin initiating recoupments without due process. This lack of awareness resulted in numerous complaints and threats of legal remedies, and highlighted the need for full development and due process. To remedy this shortcoming, our team initiated additional research action on the claims identified, requesting copies of prescriptions and documentation not only from the pharmacies, but also validating with the prescribing physician that the prescriptions were valid and that patients received corresponding medical care -that supported the medical necessity/encounter that generated the prescription.

By appropriately integrating due process and development into a comprehensive claims analysis it not only assists in rooting out administrative action, but also highlights those providers who are outliers and potentially engaging in fraudulent or abusive behavior. For example, one suspect pharmacy engaged in excessive follow-up, calling our team and their Congressional representative on a weekly basis. When additional information was requested to support the claims, this suspect pharmacy submitted

“attestations” from the prescribing providers which were obviously falsified. Through further development, while a large number of claims were found to be legitimate, a significant percentage of the remaining claims lacked medical necessity or were simply billed for services not rendered.

Through being diligent in using data analytics prevent and to root out aberrant behavior, applying appropriate administrative actions, development and education, you should be successful in deterring fraud and abuse, but you can also highlight aberrant behavior of those providers or pharmacies engaged in fraudulent practices.

Phantom Claims for HIV Drugs for Pre-Exposure Prophylaxis (PrEP®) – South Florida Providers

Submitted by Alejandra Wolf, SIU Supervisor - Pharmacy Audit & Fraud, Waste, and Abuse, Elixir

Multiple prescribers located in South Florida have been identified in a scheme related to HIV drugs for PrEP®. Three individual members from commercial plans reported similar complaints related to Truvada Tab 200-300.

One member reported that they received a coverage determination letter indicating that Truvada Tab 200-300 was not approved. The member indicated that they had never requested the drug in question. The member’s transaction history showed rejections for drug in question from a pharmacy in central FL.

A second member reported that the same pharmacy billed their prescription benefit for Truvada Tab 200-300. This member does not know the pharmacy, nor the prescriber attached to the claim in question. The member indicated that they were tested for COVID and HIV but did not specify where the testing was done.

In addition, a third member was interviewed and indicated that they had COVID testing and other blood screening done at a mobile health screening vehicle that was providing services at their residential building. The services were offered free of charge and the member indicated that they did NOT provide medical or prescription insurance information. It appears that this mobile health screening company obtained prescription billing information for the member and initiated a prior authorization for Truvada for PrEP®. Upon obtaining authorization, false claims were billed to the prescription insurance. The member indicated not needing, requesting, or receiving drug in question.

It appears that the prior authorization records submitted to the PBM are being falsified. All prior authorization records seem to indicate that members were screened for HIV risk level and determined to be high risk patients in order to meet the criteria to receive the drugs in question. All prescribers are associated with a clinic near Fort Lauderdale, FL, and the PrEP drugs were billed by the central FL pharmacy.

RST-Sanexas Therapy Treatment

Submitted by Julie Barnett, Program Integrity Supervisor, Coventbridge

A nationwide scheme has been identified affecting multiple private and government payers involving the use of the RST-Sanexas device. The Sanexas device itself has received FDA approval through the 510(k), (# K022433) process, as an interferential current (IFC) therapy device. These IFC devices are most commonly used as Transcutaneous Electrical Nerve Stimulation (TENS) units (HCPC E0730).

This scheme involves the combination of multiple “proprietary” vitamin blend injections to the affected area, most often the feet for neuropathy, and a timed session hooked up to a Sanexas machine. The Sanexas treatment plan has the patients receiving these services two-three times per week for a total of 24-36 treatments. The overwhelming majority of this scheme is being rendered by Nurse Practitioners employed at Chiropractor owned practices.

Providers engaging in this scheme are using an ever-evolving set of code combinations, but it will consistently contain at least four of the following billed on the same date of service: 96372, 97016, 97032, 97112, 97150, G0283, J3411, J3415, J3420, and J1955. They will also be using the ICD-10 code G894 for Chronic Pain Syndrome on greater than 75% of their claims.

A smaller amount of the Sanexas providers are also utilizing Epidermal Nerve Fiber Density Testing (ENFD), and a device called the TM Flow which is being used to bill autonomic nervous system function tests (ANS). The ENFD testing is using CPT codes 11104 and 11105. The ANS testing is using CPT codes 93922, 95921, and 95923.

SPOTLIGHT ARTICLES

Billing for Breast Reduction in Place of Gender Affirming Mastectomy

Submitted by Kevin Sullivan, CFE, CAMS, Blue Cross and Blue Shield of Minnesota

Background: The Special Investigations Unit of Blue Cross and Blue Shield of Minnesota received an external referral in regard to a member who may be in the process of circumnavigating the requirements of their insurance benefits in order to have a mastectomy in pursuit of gender transition. The member claimed the requirements of the insurance company were transphobic, outdated, and would take too long. The member found the insurance company would cover breast reduction surgeries with little to prove for medical necessity. Therefore, the member asked their plastic surgeon if they would bill the insurance company for a breast reduction while performing a mastectomy, to which the doctor agreed.

Records: The medical records received make it appear the member was inquiring about a breast reduction. The doctor claimed the member had seen a chiropractor, though no billing for this was found. The medical records referred to bra strap grooving, while none were seen in the photographs found of the member. Statements were made about submitting a prior authorization letter along with a phone call made to request prior authorization for the surgery, but no such records of either were found. The pre-operation records of another provider stated the member was being seen prior to a bilateral mastectomy. A later note from the plastic surgeon claimed the surgery was a mastectomy, but the billing should be done for a reduction.

Investigative Indicators: In an interview with a news reporter years before this discovery, the plastic surgeon made it clear this was a practice used to circumnavigate the requirements of insurance; therefore, this is not an anomaly. There are numerous indicators to identify possible fraud, waste, and abuse. Though the diagnosis related to this surgery was hypertrophy, the member's prior medical records documented testosterone treatments and mental health services for gender identity disorder and dual role transvestism. The member's social media was used to corroborate the desire for potential gender transition and to determine the reality of physically identifiable symptoms documented in the medical records. Social media posts done after the surgery may show further evidence of the extent of the surgery.

Agency Priorities

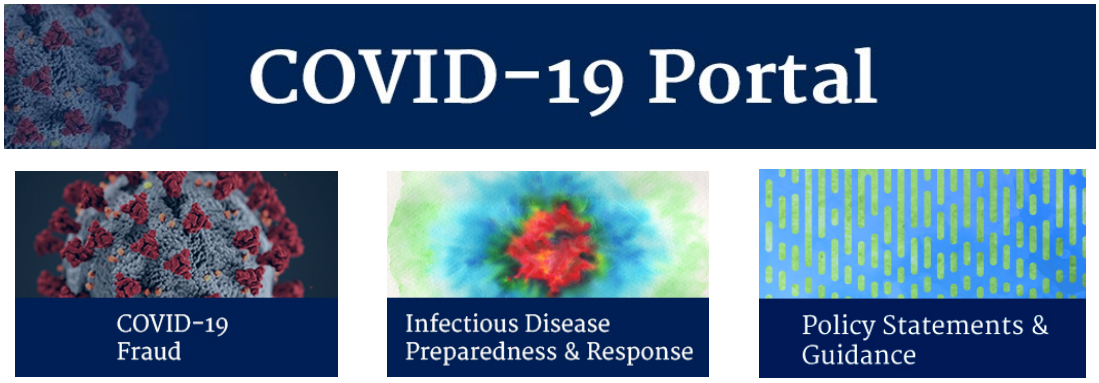
HHS-OIG

- OIG Work Plan: The OIG Work Plan sets forth various projects that are underway or are planned to be addressed during the fiscal year and beyond by OIG's Office of Audit Services and Office of Evaluation and Inspections. OIG's work portfolio also includes legal and investigative activities related to high-risk HHS programs that are the most in need of attention.

  OIG Work Plan updates are now made on a monthly basis to ensure that it more closely aligns with the work planning process. Adjustments are made throughout the year to meet priorities and to anticipate and respond to emerging issues with the resources available.

  Click here for the most current OIG Work Plan.

- Summary of OIG Priorities: For fiscal year 2021, OIG has set performance targets for the following priority areas: improve emergency preparedness and COVID-19 response and recovery; protecting beneficiaries from prescription drug abuse, including opioid abuse; addressing opioid addiction, substance abuse treatment, and serious mental illness; promoting patient safety and accuracy of payments for services furnished in home and community settings; strengthening Medicaid protections against fraud and abuse; and ensuring health and safety of children served by grant-funded programs. Additional key oversight areas include cybersecurity, prescription drug spending, managed care and non-traditional healthcare models, management of grants and contracts, oversight of technology, financial stewardship of HHS programs, the Indian Health Service and other programs serving American Indians and Alaska Natives, and HHS's emergency preparedness and response.



Reports | Enforcement Actions | Policies & Guidance | Outreach

In light of the ongoing developments related to COVID-19, OIG continues to mobilize its staff and resources to address the many and varied issues arising from this crisis. OIG's top priority is to protect the public and the health and well-being of HHS program beneficiaries. This duty is all the more important as we confront the COVID-19 pandemic. To that end, OIG has published work addressing hospital preparedness, State agency approaches to childcare, and health care facility and community-level emergency response.

OIG's COVID-19 oversight strategic plan sets forth four goals: protecting people, protecting funds, protecting infrastructure, and promoting program effectiveness now and into the future. OIG accelerated efforts to initiate data-driven reviews examining the effectiveness of the public health response through an independent and objective lens.

Consistent with Congress' call for transparency and oversight of the Federal COVID-19 response and funding, OIG continues to coordinate closely with the Pandemic Response Accountability Committee (PRAC) and other OIGs from multiple Departments responsible for the COVID-19 response.

OIG remains committed to protecting the millions of beneficiaries across the country and supporting the dedicated health care professionals who are working so hard to serve the public during this pandemic. To stay up to date on OIG's latest work related to COVID-19, click on the portal boxes appearing above.

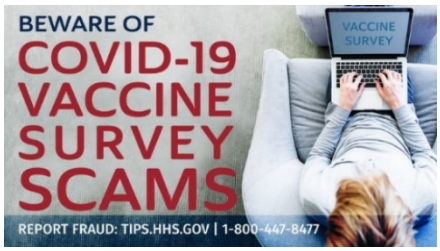
Please note that OIG's COVID-19 Portal has been redesigned and features additional resources, including a searchable list of our COVID-19 reports and downloadable graphics. The redesigned portal adds clear tabs for all of our work related to COVID-19 in one central place.

OIG Outreach: OIG is committed to keeping the public informed about general fraud schemes related to COVID-19 vaccines, health care services, and HHS grant scams. OIG mitigates the harm from these schemes by proactively alerting the public about potential scams and instructing people how to protect themselves. Appearing below are examples of OIG's outreach efforts to the general public.

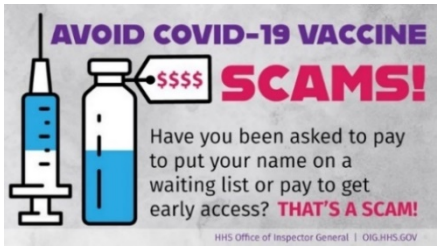
What's Trending



Vaccine Scams
Protect yourself and your loved ones from COVID-19 vaccine fraud. Be suspicious of any offer to sell or ship doses of #COVID19 vaccines in exchange for payments. Learn more: https://go.usa.gov/xAGbX.



Vaccine Survey Scams
Be cautious of #COVID19 vaccine survey scams. Do not give your personal, medical, or financial information to anyone claiming to offer money or gifts in exchange for your participation in a COVID-19 vaccine survey. Learn more: https://go.usa.gov/xsusa.



Vaccine Waiting List Scams
Requests to pay out of pocket to put your name on a waiting list or pay to receive the #COVID19 vaccine from unsolicited sources could be a scam! Ignore these unsolicited offers and report suspected scams to HHS-OIG at 800-447-8477 or http://TIPS.HHS.GOV.



Grant Fraud Scams
Fraudsters use social media for #COVID19 related scams. Scammers are hacking social media accounts to impersonate your friend or governments employees in order to send direct messages to beneficiaries about being eligible for grants—that's fraud! go.usa.gov/xsVcH.

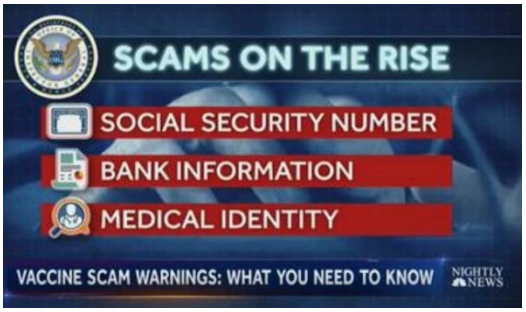
- OI Priorities: For fiscal year 2021, OI will continue to leverage modern data analytics and state-of-the-art investigative techniques to identify and target potential fraud schemes and areas of program waste and abuse. OI's top investigative priorities continue in the following areas: COVID-19 fraud schemes; CARES Act fraud schemes related to the Provider Relief Fund and HRSA's COVID-19 Uninsured Program; controlled and non-controlled prescription drug fraud; home and community-based services to include Medicare home health fraud schemes and Medicaid personal care services fraud schemes; ambulance transportation fraud; durable medical equipment fraud; diagnostic radiology and laboratory testing fraud; telemedicine fraud; genetic testing fraud; and Office of Refugee Resettlement oversight of the Unaccompanied Children (UC) Pro-gram.

  Updated COVID-19 Fraud Alert: On March 5, 2021, HHS-OIG updated its **COVID-19 Fraud Alert** with new information relating to COVID-19 vaccines and emerging fraud schemes.

  Early in the pandemic, OIG issued a Fraud Alert warning the public about bad actors who were preying on people's fears for profit, perpetrating fraud schemes, including marketing fake COVID-19 test kits and unapproved treatments through telemarketing calls, social media platforms, and door-to-door visits.

  This updated alert also provides general information on how to protect oneself and the community against bad actors. OIG will regularly update the alert with the latest information about scams that exploit the pandemic, aiming to defraud Medicare and Medicaid beneficiaries and the Federal health care programs that serve them.

  - **COVID-19 Vaccine Scams Press Release:** The Federal Bureau of Investigation (FBI), HHS-OIG, and Centers for Medicare & Medicaid Services (CMS) issued a Vaccine Scams Press Release warning the public about several emerging fraud schemes related to COVID19 vaccines. The FBI, HHS-OIG, and CMS have received complaints of scammers using the public's interest in COVID-19 vaccines to obtain personally identifiable information (PII) and money through various schemes. OIG continues to work diligently with its law enforcement partners and the private sector to identify cyber threats and fraud in all forms.



HHS-OIG ASAC Interviewed January 2021 on COVID-19 Scams

Interviews with Assistant Special Agent in Charge Nenette Day were featured by NBC Nightly News, KSFR Public Radio, and AARP. ASAC Day discussed COVID-19 vaccine scams and how the public can avoid falling victim.

- **Special Fraud Alert: Speaker Programs:** On November 16, 2020, OIG released a Special Fraud Alert highlighting fraud and abuse risks in the offer, payment, solicitation, or receipt of remuneration related to speaker programs hosted by pharmaceutical and medical device companies. OIG urged drugmakers and medical device companies to avoid soliciting and paying physicians to speak on their behalf.

  The alert is the first one issued by OIG in 6 years, and it comes as several drugmakers have found themselves ensconced in kickback-related litigation, which include cases involving Purdue Pharma and Alexion.

  Purdue Pharma's October 21. 2020, $8.3 billion settlement involved allegations it paid physicians to encourage other healthcare professionals to prescribe more of its opioids. On July 2, 2020, Alexion agreed to pay more than $21 million to settle the Securities and Exchange Commission's allegations it used bribes to improve sales of its blood disease drug Soliris in Russia and Turkey.

- **OI's Nursing Home/Emergency Medical Service Initiative:** In April 2020, HHS-OIG established the COVID-19 Cross-component Nursing Home Initiative, also known as Operation C.A.R.E. (Caring, Awareness, & Resources for our Elders).

  The emphasis of the workgroup is to engage in a multi-disciplinary approach to address rising concerns in response to the COVID-19 pandemic and its problematic implications in the nursing home community. The workgroup collaborates on impactful projects to address the health care fraud and patient harm risks that nursing homes and long-term care facilities face. Some of those risks include resident and staff safety, personal protective equipment (PPE) shortages, ensuring standards of care, infection control, and outlining successful strategies for safe and successful outcomes.

  In May 2020, OI created a national nursing home (NH) and emergency medical service (EMS) provider educational and awareness initiative due to the high number of deaths identified at nursing homes across the nation as a result of the COVID-19 pandemic.

  As part of this initiative, OI developed a course of action to educate nursing homes and EMS providers and staff by delivering information that encouraged facilities to use best practices when caring for residents, especially during the national COVID-19 pandemic. The workgroup identified nursing homes within each OI region that had COVID-19 related deaths, as well as EMS providers who were in close proximity or that provided services to the identified facilities during the period of February 1, 2020, through June 30, 2020.

  During the week of July 27, 2020, HHS-OIG deployed approximately 230 employees, including special agents and other administrative staff who conducted outreach activities at approximately 493 nursing homes and 236 EMS providers.



  Nursing homes and EMS providers were provided with posters, business cards, and additional literature that explained how to report concerns to the OIG Hotline and other Federal and State authorities involving unsafe practices resulting in COVID-19 exposure, overall quality of care, patient abuse and neglect, and fraud and misconduct related to Medicare and Medicaid. The literature also increased the visibility of OIG's efforts to protect patients and the taxpayer, and promoted OIG's mission, vision, and values.

Operation CARE: In November 2020**,** OIG launched a new webpage dedicated to the prevention and reporting of fraud, abuse, and neglect in elder care settings. The page provides resources to support the public in acting as advocates for the elder population.

The page stems from OIG's recent nursing home national outreach and awareness campaign, Operation CARE. The initiative aimed to encourage nursing home and emergency medical service staff to use best practices during the COVID-19 pandemic and report instances of suspected elder harm.

- **Strike Force Operations:** The Health Care Fraud Strike Force (Strike Force) model is comprised of interagency teams made up of investigators and prosecutors that focus on the worst offenders in regions with the highest known concentration of fraudulent activities. The Strike Force uses advanced data analysis techniques to identify aberrant billing levels in health care fraud hot spots—cities with high levels of billing fraud—and target suspicious billing patterns, as well as emerging schemes and schemes that migrate from one community to another. Data analytics will continue to be the driver for health care fraud investigations.

  Since its inception in March 2007, the Strike Force, which maintains 15 strike force teams operating in 24 districts, has charged nearly 4,000 defendants who have collectively billed the Medicare program for more than $14 billion. In addition, the HHS Centers for Medicare & Medicaid Services (CMS), working in conjunction with HHS-OIG, are taking steps to increase accountability and decrease the presence of fraudulent providers through invoking administrative actions.

  Coordinated enforcement takedowns involving Federal, State, and local agencies will continue to be part of the government's anti-fraud enforcement arsenal and a centerpiece in the fight against opioid epidemic. The allocation of the hundreds of OIG special agents and other law enforcement personnel is a clear indication of the DOJ's and OIG's commitment to combating fraud in the Federal health care programs.

  Takedowns protect Medicare and Medicaid and deter fraud—sending a strong signal that theft from these taxpayer-funded programs will not be tolerated. The money taxpayers spend fighting fraud is an excellent investment: For every $1 spent on health care-related fraud and abuse investigations in the last 3 years, more than $5 has been recovered.

  An in-depth description of the Strike Force program, its statistical successes, and ongoing investigative activities can be found at: https://oig.hhs.gov/fraud/strike-force/

- **Strike Force Location Overview:** In CY 2018, HHS-OIG, in partnership with the U.S. Department of Justice (DOJ), the FBI, and the Drug Enforcement Administration (DEA) expanded Strike Force operations to two additional regions. In August 2018, HHS-OIG and its partners formed the *Newark/Philadelphia Medicare Fraud Strike Force*, which focuses on health care fraud and illegal opioid prescriptions in the Newark/Philadelphia region. In October 2018, HHS-OIG and its aforementioned partners also created the *Appalachian Regional Prescription Opioid (ARPO) Strike Force* to focus on illegal opioid prescriptions covering nine Federal districts in five States. The mission of the ARPO Strike Force is to identify and investigate health care fraud schemes in the Appalachian region and surrounding areas, and to effectively and efficiently prosecute medical professionals and others involved in the illegal prescription and distribution of opioids. *[See map below depicting all current Strike Force locations.]*



Formed in October 2018, the ARPO Strike Force operates in Cincinnati, Louisville, Pittsburgh, Knoxville, Memphis, and Birmingham to investigate illegal opioid prescriptions in the surrounding areas. The ARPO Strike Force is made up of prosecutors and data analysts with the Health Care Fraud Unit of DOJ's Criminal Division Fraud Section, prosecutors with the U.S. Attorney's Offices in the region and special agents with the FBI, HHS-OIG, and DEA. Engaging partnerships include the Center for Disease Control's (CDC) Opioid Rapid Response Program (ORRP) team and State public health partners to address disruptions in patient care after takedown. CDC ORRTs provide clinicians with resources, expand access to medication-assisted treatment, and help build response capacity.

- **Opioid Rapid Response Program (ORRP):** HHS's ORRP team is designed to strengthen Federal, State, and local response across the country. Disrupted access to a prescriber can negatively impact patients with physical opioid dependence. Prior to a law enforcement action, the ORRP team is provided with information that can help them assess patient risk and target resources to mitigate the risk of overdose among patients of an opioid prescriber subject to a pending law enforcement action. The ORRP establishes "trusted contacts" within each state, to which information about impending actions can be provided at the time or prior to an action without compromising operational security. Trusted contacts may take immediate steps to further assess patient risk and prepare to put mitigation measures in place to decrease over-dose risks.

- **2020 National Health Care Fraud and Opioid Takedown:** In September 2020, HHS-OIG, along with our State and Federal law enforcement partners, participated in a nationwide health care fraud takedown.



The takedown focused on several schemes to include alleged tele-fraud, or scams that leverage aggressive marketing and so-called telehealth services to commit fraud. This fraudulent activity resulted in charges for 345 defendants in 51 judicial districts, including telemedicine executives, the owners of durable medical equipment (DME) companies, genetic testing laboratories, pharmacies, and more than 100 medical practitioners, for their alleged participation in health care fraud schemes involving more than $6 billion in alleged loss. In addition, Federal health care billing privileges were revoked for 256 medical professionals for their involvement in the schemes. Federal and State law enforcement personnel took part in this operation, including 175 OIG special agents.



Appearing to the left is a map of the 51 judicial districts where the takedown operation took place.

The largest amount of alleged fraud loss charged in connection with the takedown operation, relates to schemes involving telemedicine—the use of telecommunications technology to provide health care services remotely—which resulted in $4.5 billion in allegedly false and fraudulent claims submitted by more than 86 criminal defendants in 19 judicial districts.

A detailed synopsis of the cases charged as part of the 2020 National Health Care Fraud and Opioid Takedown are located here: https://www.justice.gov/criminal-fraud/hcf-2020-takedown/case-descriptions.

Case Highlights

FBI

- **Home Health Agency Fraudulent Enrollment:** FBI San Antonio initiated this investigation based on a Qui Tam complaint alleging Merida Health Care Group was knowingly providing hospice care to Medicare/ Medicaid beneficiaries who were not eligible to receive hospice care. Patients were enrolled absent a terminal illness, a requirement for hospice care, and billed Medicare and Medicaid $150 million. No physical patient harm was reported. The case was jointly investigated by DHHS-OIG, DOJ Medicare Strike Force, and the TX USAO.

    - On 12/16/2020, Rodney Mesquias, President/Owner of Merida Health Care Group was sentenced to serve 20 years in prison and pay $120M in restitution.
    - On 2/3/2021, United States District Court, Southern District of Texas, sentenced Henry McInnis, CEO of Merida Health Care Group, to serve 15 years in prison.

- **Insure Nutrition:** FBI Pittsburgh, Erie Resident Agency, initiated an investigation into Insure Nutrition (IN) predicated on information received from Highmark. IN is an online nutrition company that had been defrauding insurance companies by billing for unnecessary prescriptions and providing over the counter (OTC) protein shakes to bariatric patients. The investigation identified 19 defendants (3 individuals, 16 entities) associated with IN who billed various insurers, including Tricare, over $100 million between approximately 2012 and 2018, with losses amounting to approximately $60 million. The individual defendants together with the defendant pharmacies engaged in a series of interconnected actions that resulted in misleading advertising associated with supplying nutritional shakes; the inducement to enlist various patients in ordering the nutritional shakes resulted in the defendants and the pharmacies securing the patients' insurance information which in turn resulted in the defendants (individual defendants and by and through the pharmacies) soliciting the patients to appeal to their respective physicians to prescribe High Yield (expensive) medications. IN included unsolicited prescriptions for various OTC items, such as a compound labeled Resveratrol, with the protein shakes. The unsolicited OTC prescriptions were billed to insurance companies for thousands of dollars. Pittsburg Erie RA is investigating this matter with the Defense Criminal Investigative Service with support from FBI Los Angeles.

    - On 4/7-8/2021, brothers Mehran David Kohanbash and Joseph Kohan, and their nephew, Nima Rodefshalom, were sentenced for their roles in an elaborate fraud scheme described above. Rodefshalom and Kohanbash were sentenced to 54 months' imprisonment, and Kohan was sentenced to 42 months' imprisonment. This case involves $60 million in penalties and forfeiture – the largest forfeiture in a criminal case in the history of the Western District of Pennsylvania.
    - On 5/22/2017, FBI Pittsburg, with assistance from FBI Los Angeles and FBI Houston, executed 6 search warrants (3 pharmacies, 2 offices, 1 residence) in LA and 3 search warrants (3 pharmacies) in HO without incident. Approximately 110 FBI personnel assisted in these search warrants. Agents seized approximately 200 boxes of billing and patient records.

- **Neck Spasm:** FBI New York Field Office, Hudson Valley Resident Agency, predicated this case on information received from a source that Dolson Avenue Medical Clinic (DAM), located in Middletown New York, engaged in the fraudulent billing of Medicare, Medicaid, and Private Insurers for services not rendered or medically necessary. Additionally, separate information was developed indicating that DAM engaged in the large-scale diversion of controlled substances. James Spina (J. Spina), the owner of the family clinic, with the help of Jeffrey Spina (Jeff Spina), Kim Spina (K. Spina) and Andrea Grossman (Grossman), ultimately billed insurers for medically unnecessary services and procedures, submitted claims for services not rendered, double-billed for services, fabricated medical records, and concealed the fraud by blocking audits by Medicare and other insurers. This was a 6 year approximately $80 million insurance fraud scheme. The

investigation is being worked jointly with HHS-OIG, NICB, New York State Comptroller's Office and members of the Hudson Valley White Collar Crime Task Force, including Orange County Sheriff's Deputies, and Orange County District Attorney's Office Investigators.

  - On 8/23/2017, 5 search warrants were successfully executed at 5 locations associated with DAM including 4 office buildings and 1 storage unit. Approximately 100 FBI, HHS-OIG, and NY State Comptroller personnel participated in the searches.
  - On 4/13/2021, J. Spina, DAM owner, was sentenced to 108 months (9 years) and 3 years of supervised release for 1 count of Conspiracy to Commit Healthcare Fraud. In addition to the prison term, J. Spina was ordered to pay $9,760,555.20 in restitution, and to forfeit $9,105,741.61.
  - DAM treated approximately 3,000 patients per week out of an approximately 3,000 square foot treatment office. Patients were brought into the clinic through various marketing techniques including the promise of free massages. Once the patient was inside the clinic, DAM employees were instructed to pitch additional treatments and acquire patient insurance information.
  - The clinic owner, J. Spina, pressured the patients to receive more services. Once DAM was in possession of patient insurance information, DAM billed insurance for services not rendered.
  - If a patient was covered by more than one insurance, DAM would bill each insurance for the same treatment.

- **Unnecessary Back Injections:** FBI Detroit opened this case after receiving a request from the DOJ Medicare Strike Force to open a joint investigation with HHS-OIG. The investigation was predicated based upon analytics prepared by the HCF Strike-Force concerning Tri-County Physician Group, PC, (Tri-County) employed Physicians located in the Eastern District of Michigan. Evidence presented at the trial of Spilios Pappas, Joseph Betro, Tariq Omar, and Mohammed Zahoor revealed a scheme to administer unnecessary back injections to patients in exchange for prescriptions of over 6.6 million doses of medically unnecessary opioids. Patients were required to get the injections in order to get the prescriptions, some of which were resold on the street by drug dealers. The four doctors were practicing medicine in Michigan and Ohio up until trial. The overall fraud scheme by Tri-County defrauded Medicare of over $150 million by billing for medically unnecessary facet joint injections, unnecessary urinary drug screens, home health and other unneeded items to include prescriptions. There was patient harm and the perpetrators from Tri-County are no longer in business. Case was worked jointly with HHS-OIG and IRS.

  - From 10/3/2017 to 6/28/2018, 8 physicians, 2 Licensed Physical Therapists, 1 Physical Therapy Assistant, 2 Managers of two clinics, and 4 other individuals who worked for Tri-County plead guilty. The guilty pleas included false statements, conspiracy to commit HCF, money laundering, and conspiracy to defraud the U.S. Government, pay, and receive health care kickbacks.
  - On 3/3/2021 Mashiyat Rashid, CEO of Tri-County, was sentenced to 15 years in prison, 4 years supervised release, ordered to pay $51,396,917.70 in restitution which included the forfeiture of $11,500.00.00 from commercial and residential real estate and a Detroit Pistons season ticket membership.

HHS-OIG

Affordable Care Act (ACA)

- **Father and Son Who Defrauded Numerous State Affordable Care Act Programs Sentenced to Prison:** In February 2021, two California residents were sentenced for defrauding Affordable Care Act programs in at least 12 States of more than $27 million. Jeffrey White, 63, was sentenced to 36 months of imprisonment and 3 years of supervised release, and Nicholas White, 35, was sentenced to 13 months of imprisonment and 3 years of supervised release.

  According to court documents and statements made in court, Jeffrey White and his son, Nicholas White, conspired to defraud health care plans operating under the Affordable Care Act (ACA, commonly referred to as “Obamacare”) in Connecticut and other States by fraudulently enrolling individuals in ACA plans in States where the individuals did not live. In order to further the conspiracy, the Whites created phony residential leases using fictitious landlords in various States, including locations in Danbury, Farmington, Hartford and Norwalk, Connecticut. The Whites also used an online application to obtain false cell phone numbers for the individuals with area codes that made it appear that the individuals lived at the fictitious addresses, and provided the false cell phone numbers to the ACA plans. If anyone at the ACA plan called the false local number, the call would ring through to a phone controlled by the Whites.

  In order to enroll the individuals in an ACA plan, the Whites paid the insurance premiums for the individuals, and also paid to have the individuals transported to California where the individuals were placed in expensive residential substance abuse treatment programs. The treatment programs then billed the ACA plans for thousands of dollars of treatment each week, including claims for expensive laboratory tests such as blood or urine toxicology screenings.

  The treatment programs paid the Whites thousands of dollars in kickbacks for each referral, and some programs arranged for the Whites to receive a percentage of the money the treatment programs received from the ACA health insurance plans. In order to maximize their proceeds from the fraud scheme, the Whites enrolled the individuals in ACA plans in States that paid the highest amount for substance abuse treatment, even though the individuals did not live in those States.

  The Whites have admitted that their scheme resulted in more than $27 million in losses to ACA plans across the country, including plans in Connecticut, Arizona, California, Delaware, Indiana, Kentucky, New Jersey, Ohio, Oregon, Pennsylvania, Tennessee, and Texas.

  Although the Whites personally profited approximately $1 million through this scheme, they were ordered to pay restitution in the approximate amount of $27.6 million.

  The U.S. Attorney for the District of Connecticut noted that this case is believed to be the first of its kind involving fraudulent enrollment of individuals in ACA plans on a national scale.

  This case was investigated by HHS-OIG, the FBI, IRS-CI, and the U.S. Postal Inspection Service.

COVID-19

- **Woman First in the Nation Charged with Misappropriating Monies Designed for COVID Medical Provider Relief:** In February 2021, Amina Abbas, a Michigan woman was indicted on allegations that she intentionally misappropriated government funds that were designed to aid medical providers in the treatment of patients suffering from COVID-19 and used them for her own personal expenses. Abbas was charged with embezzlement of government proper-ty.

  The indictment includes the first criminal charges for the intentional misuse of funds in-tended to provide relief to health care providers and maintain the access to medical care during the pandemic, money set aside to help Americans get needed medical care in a global health and economic crisis.

  The indictment alleges that Abbas previously owned "1 on 1 Home Health" (1 on 1), which she had closed in early 2020 after Medicare issued an overpayment demand for approximately $1.62 million because 1 on 1 had submitted claims for patients who did not qualify for home health services. According to the indictment, 1 on 1, which was never operational during the pandemic, received approximately $37,657 designated for the medical treatment and care of COVID-19 patients. Abbas then allegedly misappropriated the funds by issuing checks to her family members for personal use.

  The case was investigated by HHS-OIG and the FBI.

- **More Charges Against State Lawmaker for $900,000 COVID-19 Fraud Scheme at Springfield Health Care Charity - Lift Up Received Nearly $300,000 for COVID-19 Testing Already Paid for by Clients at For-Profit Clinics:** In March 2021, additional charges were returned by a Federal grand jury against an elected Missouri State representative for a nearly $900,000 COVID-19 fraud scheme, following her indictment in February for a separate fraud scheme in which she made false claims about a supposed stem cell treatment marketed through her clinics in south-ern Missouri, and for illegally providing prescription drugs to clients of those clinics.

  Patricia "Tricia" Ashton Derges, of Nixa, Missouri, was charged in a 23-count superseding indictment returned under seal by a Federal grand jury in Springfield, Missouri. The superseding indictment replaces the original indictment returned in February 2021 and includes three new counts of COVID-19 fraud in addition to the original charges.

  Derges was elected in November 2020 as a Missouri State representative in District 140 (Christian County). Derges, who is not a physician but is licensed as an assistant physician, operates three for-profit Ozark Valley Medical Clinic locations in Springfield, Ozark, and Branson, Missouri, Derges also operates the non-profit corporation Lift Up Someone Today, Inc., with a medical and dental clinic in Springfield to serve the poor, homeless, and uninsured.

  The indictment issued in March alleges that Derges fraudulently received $296,574 in CARES Act funds for Lift Up, although Lift Up did not provide any COVID-19 testing services to its patients. In fact, Lift Up's medical clinic closed at the beginning of the COVID-19 pandemic and remained closed from March to June 2020.

  Derges allegedly sought CARES Act funding for COVID-19 testing that had been pro-vided, and already paid for, at her for-profit Ozark Valley Medical Clinic. According to the indictment, Derges requested reimbursement for $379,294 in COVID-19 testing and related expenses, and future funding in the amount of $503,350. In total, Derges ap-plied for $882,644 from the CARES Act Relief Fund on Lift Up's behalf.

Derges claimed in her application to the Greene County CARES Act Relief Fund that Lift Up provided COVID-19 testing and she sought reimbursement for "COVID-19 eligible expenses" that Lift Up had incurred. To support her claim, Derges provided in-voices totaling $296,574 from Dynamic DNA for more than 3,000 COVID-19 laboratory tests. Derges submitted the Dynamic DNA invoices as Lift Up expenditures, although they were actually for testing done at Derges's for-profit Ozark Valley Medical Clinic. Lift Up, a non-profit charity, and Ozark Valley Medical Clinic, a for-profit corporation, are separate legal entities. According to the indictment, Ozark Valley Medical Center had already received payment from its clients of approximately $517,000 for these COVID-19 tests. Ozark Valley Medical Center charged clients, patients, or their patient's employer approximately $167 per sample for its COVID-19 testing services. Derges allegedly concealed from Greene County that these COVID-19 tests had al-ready been paid for by other payors.

In December 2020, the Greene County Commission awarded Lift Up $296,574 in CARES Act funding based upon Lift Up's fraudulent application and the Dynamic DNA invoices Derges had submitted. Derges deposited the check into Lift Up's bank account, then transferred the funds into Ozark Valley Medical Center's bank account.

Derges provided several more invoices from Dynamic DNA to Greene County later in December 2020 to further support her application for Lift Up, the indictment says, although the invoices were actually for testing done for clients at Ozark Valley Medical Center, raising the total to $589,143 for 6,177 COVID-19 tests. Derges allegedly concealed from Greene County that Ozark Valley Medical Center already had been paid approximately $1 million by clients, patients, or their patients' employers, for these COVID-19 tests.

Ozark Valley Medical Center's COVID-19 testing services were a financial boon for the corporation, according to the indictment. Between January 2015 and May 19, 2020, Ozark Valley Medical Center's daily bank account balance never exceeded $50,000. On September 22, 2020, for example, the daily bank account balance was over $345,000.

Wire Fraud Scheme

The superseding indictment contains the original eight counts of wire fraud related to a nearly $200,000 fraud scheme, which lasted from December 2018 to May 2020. Derges allegedly marketed a stem cell treatment that actually utilized amniotic fluid that did not contain any stem cells.

The Controlled Substances Act

The superseding indictment contains the original 10 counts of distributing Oxycodone and Adderall over the internet without valid prescriptions. The indictment alleges that Derges, without conducting in-person medical evaluations of the patients, wrote electronic prescriptions for Oxycodone and Adderall for patients and transmitted them to pharmacies over the internet.

This case was investigated by the FBI, HHS-OIG, and the DEA.

Durable Medical Equipment

- **Durable Medical Equipment Company Owner Sentenced to Federal Prison for Bribery and Conspiracy – Defendant is Part of Record-Setting Telemedicine Fraud Prosecutions in Southern District of Georgia:** In February 2021, Patrick Wolfe, a Florida man who operated a durable medical equipment company, was sentenced to Federal prison for participating in a commercial bribery conspiracy that involved a health care program. Wolfe, the operator of Wilmington Island Medical Inc. (dba, WI Medical Inc.), was sentenced to 24 months in prison by after pleading guilty to one count of Conspiracy. Wolfe was also ordered to pay $549,476 in restitution, and after completion of his prison term must serve 3 years of supervised release.

  Wolfe pleaded guilty to paying kickbacks in return for "leads," which were in actuality signed orders from physicians and nurse practitioners, and then billing those orders to a Medicare Advantage plan using WI Medical.

  The financial total for orders facilitated through this scheme is alleged to be in the mil-lions of dollars. Medicare beneficiaries were located in the Southern District of Georgia and elsewhere.

  This matter was investigated by HHS-OIG, the FBI, and the U.S. Secret Service.

  The Southern District of Georgia has now charged 31 individuals and companies as part of the nationwide crackdown on fraudulent genetic testing, and prescribing of orthotic braces and pain creams, identifying more than $1.5 billion in losses to Medicare and Medicaid for defendants charged int the Southern District alone.

  This nationwide investigation is ongoing. As telemedicine becomes an increasing part of our healthcare system, particularly during the COVID-19 pandemic, vigilance in ensuring that fraud and kickbacks do not usurp the legitimate practice of medicine by electronic means is more important than ever.

- **North Carolina Durable Medical Equipment Corporation Sentenced for $10 Mil-lion Healthcare Fraud Scheme, and the Company and Its Owner Agree to Pay Millions to Resolve Related Civil Claims**: In March 2021, a North Carolina corporation was sentenced to 5 years' probation and ordered to pay a $2 million fine in addition to paying over $10 million in restitution to the North Carolina Medicaid Program on a charge of Healthcare Fraud. The company and its owner also agreed to pay millions to the United States and State of North Carolina to resolve related civil claims under the Federal and State False Claims Acts. In that same civil action, the Governments obtained a multimillion-dollar judgment against one of the company's employees.

  According to court documents, A Perfect Fit for You, Inc., was a durable medical equipment provider located in Morehead City, North Carolina, and owned by Margaret A. Gibson. Between March 2015 and November 2016, one or more employees of A Perfect Fit for You submitted fraudulent billings claims to Medicaid for providing durable medical equipment to Medicaid recipients. These fraudulent claims contained the personal identifying information of Medicaid recipients who had never ordered nor received any durable medical equipment from A Perfect Fit for You. In fact, some of the patients had been deceased years before the false claims were even submitted. This scheme resulted in an estimated loss to Medicaid of approximately $10.1 million.

  After appointment of a receiver, A Perfect Fit for You, Inc. self-reported suspected fraudulent activity to the North Carolina Medicaid Investigations Division. Thereafter, the company cooperated throughout the investigation.

On December 13, 2017, the United States and State of North Carolina filed a civil complaint under the Federal and State False Claims Acts against A Perfect Fit for You, Inc., and Gibson, as well as one of the company's employees, Shelley P. Bandy. To re-solve the claims, the company agreed to pay over $20.13 million, while Gibson has agreed to pay $4 million. As for Bandy, the United States and State of North Carolina have obtained over a $34.7 million default judgment against her in the civil action.

This matter was investigated by HHS-OIG, the North Carolina Department of Justice's Medicaid Investigations Division.

Electronic Health Records / Prescription

- **Electronic Health Records Technology Vendor to Pay $18.25 Million to Resolve Kickback Allegations:** In January 2021, athenahealth Inc. (Athena), a national electronic health records (EHR) technology vendor based in Watertown, Massachusetts, agreed to pay $18.25 million to resolve allegations that it violated the False Claims Act by paying unlawful kickbacks to generate sales of its EHR product, athenaClinicals.

  In a complaint filed in conjunction with settlement, the United States alleged that Athena violated the False Claims Act and the Anti-Kickback Statute through three marketing programs.
  - First, Athena invited prospective and existing customers to "Concierge Events," providing free tickets to and amenities at sporting, entertainment, and recreational events, including trips to the Masters Tournament and the Kentucky Derby with complimentary travel and luxury accommodations, meals, and alcohol.
  - Second, Athena paid kickbacks to its existing customers under a "Lead Generation" program designed to identify and refer new prospective clients to Athena. Under this program, Athena paid up to $3,000 to existing customers for each new client that signed up for Athena services, regardless of how much time, if any, the existing customer spent speaking to or meeting with the new client.
  - Finally, Athena entered into deals with competing vendors that were discontinuing their EHR technology offerings to refer their clients to Athena. Under such deals, Athena paid remuneration to the competitor based on the value and volume of practices that were successfully converted into Athena clients.

  "Across the country, physicians rely on electronic health records software to provide vital patient data. Kickbacks corrupt the market for health care services and risk jeopardizing patient safety," said U.S. Attorney Andrew E. Lelling for the District of Massachusetts.

  The settlement resolves allegations originally brought in lawsuits filed under the qui tam, or whistleblower, provisions of the False Claims Act by two separate whistleblowers. The whistleblower share to be awarded in connection with the settlement has not been determined.

  This matter was investigated by HHS-OIG, the FBI, VA-OIG, and the USPS-OIG.

Genetic Testing

- **Pennsylvania Man Admits Role in $4.6 Million Kickback Scheme Related to Genetic Testing:** In March 2021, Jeremy Richey, of Mars, Pennsylvania, admitted his role in a conspiracy to receive kickbacks and bribes from laboratories in exchange for referrals of patient DNA samples and genetic tests.

  According to documents filed in this case and statements made in court:

  Richey and certain conspirators operated Ark Laboratory Network LLC (Ark), a company that purported to operate a network of laboratories that facilitated genetic testing. Through Ark, Richey and others submitted or caused to be submitted referrals for genetic tests and patients' DNA samples to various clinical laboratories across the country. Richey and certain conspirators entered into kickback agreements with certain clinical laboratories under which the laboratories paid Ark bribes in exchange for delivering DNA samples and orders for genetic tests. Ark concealed these kickback arrangements through issuing sham invoices to laboratories that purportedly reflected services provided at an hourly rate even though the parties had already agreed upon the bribe amount, which was based on the revenue the laboratories received from Medicare or an amount paid for each DNA sample. From January 2018 through January 2019, Medicare paid these laboratories at least approximately $4.6 million for genetic tests that resulted from the referrals and DNA samples that Ark delivered to the laboratories in exchange for bribes. In turn, the laboratories paid Ark at least $1.8 million in bribes.

  The charge to which Richey pleaded guilty carries a maximum penalty of 5 years in prison and a fine of $250,000, or twice the gross grain or loss from the offense.

  This case was investigated by HHS-OIG and special agents of the U.S. Attorney's Office for the District of New Jersey.

- **Owner of Georgia Consulting Company and Texas Man Charged in $2.7 Million Genetic Testing Kickback Scheme:** In February 2021, the owner of a Georgia consulting company and a Texas man were charged in connection with their roles in a conspiracy to pay kickbacks and bribes in ex-change for referrals of patient DNA samples and genetic tests to a laboratory.

  John Berberian, of Atlanta, Georgia, and Christopher Lytle, of Desoto, Texas, were each charged with conspiracy to violate the Anti-Kickback Statute.

  According to documents filed in this case and statements made in court:

  - Berberian owned and operated a consulting company based in Atlanta. The consulting company entered into agreements with marketing and sales groups, which acquired patients' DNA samples and physicians' orders for the purpose of submitting those samples and orders to clinical laboratories for genetic tests and related services. Lytle partnered with Berberian and others to recruit and oversee these patient acquisition groups.
  - From as early as June 2018 through November 2018, Berberian, Lytle, and others conspired to offer and pay kickbacks and bribes to Ark Laboratory Network LLC, a patient acquisition group. These kickbacks and bribes were paid in ex-change for Ark's referral of patient DNA samples, including from beneficiaries in New Jersey, to Personalized Genetics LLC, d/b/a Personalized Genomics (PGL), a clinical laboratory in Pittsburgh, Pennsylvania, for genetic testing. PGL, in turn, via a billing company associated with Berberian billed and obtained payment from Medicare for these genetic tests. Berberian's consulting company paid Ark $957,783 in kickbacks and bribes in exchange for DNA samples and physicians' orders it delivered to PGL. As a result of the claims PGL submitted to Medicare for the related genetic tests, Medicare paid PGL more than $2.7 million.

- Berberian, Lytle, and others arranged for PGL to enter into a sham contract with Ark in order to make it look like Ark had agreed to provide various marketing, call center, and other services for PGL for $500 per hour. In reality, the consulting company, not PGL, paid Ark in exchange for DNA samples and physicians' orders. The amount it paid Ark bore no relation to the amount of hours Ark billed for the phony services identified in the sham contract. Instead, the payments were based on the number of samples that Ark delivered to PGL—for ex-ample, $1,500 per individual sample for genetic tests related to a patient's hereditary predisposition for cancer and approximately 50 percent of the net revenue that PGL received from Medicare for pharmacogenomic tests (referred to in the complaint as the "Bribe Formula.")
- To conceal the payment of kickbacks and bribes to Ark, Berberian, Lytle, and others directed Ark to draft and submit, via the consulting company, sham in-voices to PGL that purported to bill for hourly services at a rate of $500 per hour. Berberian and Lytle, however, had already determined with Ark the amount of kickbacks and bribes that the consulting company would pay Ark pursuant to the Bribe Formula. Ark's sham invoices, which typically repeated the same identical description of services, including "conference calls" and "prospective Ark client visits," simply adjusted the total amount of hours billed so that the amount due under the invoice equaled the same amount due to Ark un-der the Bribe Formula.

This case was investigated by HHS-OIG and special agents of the U.S. Attorney's Office for the District of New Jersey.

Grant Fraud | Thousand Talents Program

- **Former University of Florida Researcher Indicted for Scheme to Defraud National Institutes of Health and University of Florida:** In February 2021, Lin Yang, a former University of Florida (UF) professor and re-searcher and resident of China, was indicted for fraudulently obtaining $1.75 million in Federal grant money from the National Institutes of Health (NIH) by concealing support he received from the Chinese government and a company that he founded in China to profit from that research. Yang, who resided in Tampa, Florida, at the time of the offenses, was charged with six counts of wire fraud and four counts of making false statements to an agency of the United States.

  According to the indictment, Yang obtained a $1.75 million grant from NIH to develop and disseminate an imaging informatics tool for muscles known as "MuscleMiner." Be-tween September 2014 and July 2019, Yang served as the principal investigator for the NIH grant at UF. As the principal investigator, Yang was responsible for conducting and administering the grant in compliance with applicable Federal law and institutional policies. Among other things, Yang was required to disclose his foreign research support and financial conflicts of interest, including his ownership of, or interest in, a foreign company.

  During that same period, in 2016, Yang established a business in China known as "Deep Informatics." The indictment further alleges that Yang promoted his business in China by relating that its products were the result of years of research supported by millions of dollars of U.S. Government funding. Simultaneously, Yang applied for and was accept-ed into the People's Republic of China's Thousand Talents Program (TTP) in connection with Northwestern Polytechnical University, located in Xi'an, China. The TTP was a talent plan established by the Chinese government to encourage the transfer of original ideas, technology, and intellectual property from foreign institutions, such as American universities.

  In order to maintain his employment with UF and continue receiving NIH grant money, the indictment alleges that Yang intentionally concealed his conflicts of interest and other support in connection with his Chinese business and his participation in a Chinese government talent plan and affiliation with a Chinese research university. On multiple occasions, Yang submitted disclosures to NIH containing false statements and material omissions concerning his affiliations

and research endeavors with a foreign government and company. Additionally, in January 2019, UF's College of Engineering required all faculty to provide, in writing, updated disclosures concerning activities with foreign entities in China and two other countries. The indictment alleges that Yang provided UF with a written response that falsely stated he had no affiliation with any business, entity, or university in China.

Yang traveled to China in August of 2019 and has yet to return to the United States.

The FBI and HHS-OIG investigated this case. The U.S. Attorney's Office for the Northern District of Florida is prosecuting the case with assistance from the National Security Division's Counterintelligence & Export Section.

- **Davis Man Pays $635,000 in Civil Settlement to Resolve Allegations of False Statements to Obtain Grant Frauds:** In March 2021, Owen Hughes, the sole proprietor of Eon Research Corporation in Da-vis, agreed to pay the United States $635,000 to resolve allegations that he knowingly submitted false statements to the National Institute of Environmental Health Sciences to secure Small Business Innovation Research grant funds.

  According to court documents, in 2007, Hughes applied for and received a Small Business Innovation Research grant to conduct environmental research, certifying that he had implemented financial safeguards to ensure the proper use of grant funds.

  The settlement resolves allegations that despite his certifications, Hughes had no financial policies in place. As a result, Hughes could not substantiate how he had actually used the Federal funds he received. The settlement also resolves claims that Hughes commingled grant funds in his personal accounts and then used the commingled funds for his aviation hobby, by paying aircraft hangar rental fees and buying aircraft parts.

  This case was the result of an investigation by HHS-OIG.

Home Health

- **Two Women Indicted on Charges Stemming From $100 Million Home Health Care Fraud and Money Laundering Scheme – Government Seeks Civil Forfeiture of Five Properties and 40 Financial Accounts and Investments:** In February 2021, two women were arrested and charged in connection with a $100 million home health care fraud scheme. The government also filed a civil action seeking forfeiture of five properties and 40 financial accounts and investments involved in a scheme to launder the ill-gotten gains.

  Faith Newton of Westford, and Winnie Waruru of Lowell, were each indicted on one count of conspiracy to commit health care fraud; one count of health care fraud–aiding and abetting; and one count of conspiracy to pay and receive kickbacks. Newton was also indicted on one count of money laundering conspiracy and seven counts of money laundering. In addition, Waruru was indicted on two counts of making false statements and one count of making a false statement in a health care matter.

  According to the indictment, from January 2013 to January 2017, Newton was part owner and operator of Arbor Homecare Services LLC. Waruru was a Licensed Practical Nurse employed as a home health nurse at Arbor. It is alleged that Newton and Waruru engaged in a conspiracy to use Arbor to defraud MassHealth and Medicare of at least $100 million by committing health care fraud and paying kickbacks to induce referrals. Newton then allegedly laundered the ill-gotten gains.

Specifically, it is alleged that Arbor, through Newton and others, failed to train staff, billed for home health services that were never provided or were not medically necessary and billed for home health services that were not authorized. Arbor, through New-ton and others, developed employment relationships as a way to pay kickbacks for patient referrals, regardless of medical necessity requirements. They also entered sham employment relationships with patients' family members to provide home health aide ser-vices that were not medically necessary and routinely billed for fictitious visits that Newton knew did not occur. As alleged in the civil complaint, Newton either directly or through Arbor, targeted particularly vulnerable patients who were low-income, on disability and/or suffering from depression and/or addiction.

According to the indictment, Waruru and Arbor billed MassHealth for Waruru's skilled nursing visits, many of which she did not perform. Waruru also passed cash payments from Newton to an Arbor patient to retain that patient.

Newton allegedly used the laundered proceeds of the $100 million scheme to purchase multiple homes and a Maserati and to fund investment accounts, a lavish lifestyle, and numerous financial transactions. The civil forfeiture case seeks to forfeit to the United States five properties in Westford, North Andover, Chelmsford, and Dracut and to forfeit the contents of 40 bank accounts and/or investments.

This case was investigated by HHS-OIG, IRS-CI, and the FBI.

- **Physician Pays Nearly Half Million Dollars to Resolve Home Health Care Fraud Allegations:** In March 2021, Truc Le, Doctor of Osteopathic Medicine from Bellaire, Texas, paid to resolve allegations that he falsely certified patients for home health services and received improper payments.

  In 2016, authorities began an investigation into a home health agency known as Unified Medical Group Inc. That investigation appeared to show Le had certified patients for home health services without any knowledge of the patients' medical condition or homebound status. Instead, Le signed forms that Unified representatives provided to him on a regular basis. In addition, Unified sent improper payments to Le in violation of the Anti-Kickback Statute.

  Le has agreed to pay $475,000 to resolve the allegations.

  This case was investigated by the HHS-OIG, the FBI, and Texas MFCU.

Hospice

- **Novus Hospice CEO Pleads Guilty to Healthcare Fraud:** In March 2021, Bradley J. Harris, CEO of Novus Hospice—and former head of Novus and Optimum Health Services—pleaded guilty to defrauding Medicare and Medicaid, and conspiracy to commit healthcare fraud.

  According to his plea papers, Mr. Harris admitted that from 2012 to 2016, he billed Medicare and Medicaid for hospice services that were not provided, that were not directed by a medical professional, or that were provided to patients who were not actually eligible for hospice care. He further admitted that he used blank, pre-signed con-trolled substance prescriptions to dole out potent drugs without physician input.

  Mr. Harris admitted that two of his coconspirators, Dr. Mark Gibbs and Dr. Laila Hirjee, frequently certified that that his hospice patients faced terminal illnesses without actually examining with the patients in person, as required by Medicare. The doctors were paid around $150 for each false order they signed.

Mr. Harris also admitted that Dr. Gibbs, Dr. Hirjee, and another physician, Dr. Charles Leach, left him blank controlled substance prescriptions, sometimes a whole pad at a time. This allowed Mr. Harris, an accountant by trade, to "prescribe" schedule II con-trolled substances to hospice beneficiaries without the guidance of a medical professional.

In plea papers, Mr. Harris admitted that in summer 2014, he realized he could avoid exceeding Medicare's aggregate hospice cap by enrolling an influx of first-time hospice patients. So, he negotiated an agreement with a company called Express Medical that al-lowed him to access potential patient's confidential medical information in return for using Express Medical for laboratory services and home health visits. His wife and other Novus staff then called on individuals that had at some point been patients of Express Medical to recruit them for Novus hospice services, regardless of whether they were eligible to receive benefits.

When CMS suspended Novus based upon credible allegations of fraud, Mr. Harris simply transferred patients from Novus to a new company, "Company A." Dr. Gibbs became a medical director for the "new" hospice company, which used Novus staff and transferred hospice reimbursements back to Novus. As a result of his criminal enterprise, Mr. Harris now faces up to 14 years in Federal prison.

This case was investigated by HHS-OIG, the FBI, and the Texas MFCU.

- **Hospice Administrator Sentenced for Role in Hospice Fraud Scheme:** In February 2021, Antonio Olivera, 80, the administrator of a Southern California hospice, was sentenced to 30 months in prison for his role in a multimillion-dollar hospice fraud scheme. Olivera was also ordered to pay approximately $2.2 million in restitution.

  As part of his guilty plea, Olivera admitted that from 2011 to 2018, while acting as administrator for Mhiramarc Management LLC (Mhiramarc), a hospice located in Downey, California, Olivera and others paid illegal kickbacks to patient recruiters for the referral of hospice beneficiaries to Mhiramarc. Moreover, when clinical staff at Mhiramarc determined beneficiary referrals did not qualify to receive hospice services, Olivera overruled those determinations and nonetheless caused the beneficiaries to be put on hospice service.

  Olivera and co-conspirators caused Mhiramarc to submit approximately $28 million in claims to Medicare, which resulted in the company being paid over $17 million. Olivera was personally responsible for over $4.76 million in false and fraudulent claims to Medicare, resulting in Medicare paying Mhiramarc over $2.98 million for medically unnecessary hospice services for beneficiaries, many of whom had been recruited through illegal kickbacks.

  This case was investigated by the FBI's Los Angeles Field Office and HHS-OIG's Los Angeles Regional Office. Trial Attorneys Justin Givens and Claire Yan of the Criminal Division's Fraud Section are prosecuting the case.

Laboratory Fraud

- **Owners of Defunct Urine Drug Testing Laboratory Agree to Pay Over $2 Million and $4.5 Million Respectively to Resolve Allegations of Participation in Kickback Schemes:** In March 2021, the United States settled claims against Philip McHugh and Douglas Smith, former owners of Physicians Choice Laboratory Services (PCLS), a now-defunct diagnostic testing laboratory formerly located in Charlotte, North Carolina and Rock Hill, South Carolina, to resolve claims that they violated the Anti-Kickback Statute (AKS). As a result of their schemes, McHugh and Smith caused PCLS to submit millions of dollars in false claims for reimbursement to the Medicare program in violation of the Federal False Claims Act (FCA). McHugh agreed to pay over $2 million, and Smith agreed to pay $4.5 million for their respective roles in perpetrating this fraud.

In June 2019, the United States filed FCA claims against McHugh, Smith, PCLS, and other agents of the laboratory based on allegations that they participated in various schemes to offer or provide benefits to physicians in exchange for the referral of patient samples for drug testing.

The settlement against Smith resolves allegations that from September 2012 through July 2014, PCLS submitted false claims to the Medicare program as a result of Smith's payment of kickbacks to the owner of a medical practice in Knoxville, Tennessee.

The settlement against McHugh resolves allegations that during the time period beginning on June 20, 2013, and continuing through October 26, 2015, PCLS submitted false claims to the Medicare program as a result of McHugh's participation in various kick-back schemes, including (1) the provision of urine drug testing equipment, including desktop analyzers and associated supplies and services, to two physicians; (2) PCLS' payment of volume-based commissions, and later a salary, to an individual in exchange for that individual's exercise of influence over two physician practices; and (3) the pro-vision of loans to two physicians—all with a purpose to induce the referral of quantitative urine drug tests to PCLS.

In December 2019, another defendant, Manoj Kumar, a former sales representative and manager of PCLS, paid $649,407 to resolve claims that he participated in schemes to il-legally induce physicians to refer patients to PCLS for medically unnecessary urine drug tests.

The government's lawsuit resulted from two whistleblower complaints filed under the qui tam provisions of the False Claims Act.

This case was investigated by HHS-OIG and the U.S. Attorney's Office for the West-ern District of North Carolina.

- **Owner of Tennessee Drug Screening Lab Sentenced to 36 Months on Federal Health Care Fraud Charge:** In March 2021, Michael Dube, who formerly owned and operated American Toxicology Labs, was sentenced to 36 months in Federal prison. Dube, of Johnson City, Tennessee, previously pleaded guilty to two felony counts of health care fraud (one filed in the Western District of Virginia and one filed in the Eastern District of Kentucky).

  According to court documents, in March 2011, Michael Dube pleaded guilty in the Eastern District of Tennessee to one count of intentionally omitting information from reports as required under the Controlled Substances Act. As a result of his conviction, HHS-OIG informed Dube in a letter dated June 29, 2012, that he was excluded from participating in any Federal health care program.

  Nonetheless, in May 2013, Michael and his wife, Regan Dube, established American Toxicology Labs [ATL] in Johnson City, Tennessee, with Regan Dube serving as the company's registered agent, and using the couple's home address as the principal office and mailing address. ATL then applied to participate in Medicare and Medicaid. On the applications, Regan Dube was listed as the owner of ATL, and Michael Dube's name and participation in ATL was omitted.

  ATL conducted urine screens for various entities who represented themselves to be opioid treatment facilities. Between May 1, 2014, and January 31, 2020, Medicare, Virginia Medicaid, Kentucky Medicaid and TennCare made payments to ATL that totaled approximately $8.5 million. During this time, Michael Dube made employment decisions, negotiated business arrangements with providers, and otherwise participated in the management of ATL.

  In addition, Michael Dube also received kickback payments from third parties for refer-ring individuals to those third parties for services for which payment was made (in whole or in part) by federal health care programs. These payments were deposited in Michael and Regan Dube's personal checking account in a total amount of $441,646. Regan Dube was previously convicted and sentenced in connection with the scheme.

As a result of their convictions, Regan and Michael Dube will pay a total of $9,015,046, plus interest, divided between special assessments, fines, restitution, and forfeiture. They will have to repay all of the money they received from Medicare and Medicaid programs.

This case was investigated by FDA-OCI, HHS-OIG, the Virginia MFCU, DEA, IRS-CI, and the Tennessee Bureau of Investigation.

Medicaid

- **Owner of Mental Health Services Agency Pleads Guilty to Health Care Fraud Charge:** In March 2021, Wali Muhammad of Branford, Connecticut, pleaded guilty to one count of health care fraud for billing Medicaid for psychotherapy services that were not rendered or rendered by unlicensed individuals. As part of his plea, Muhammad agreed to pay $574,034 in restitution to Medicaid.

  According to court documents and statements made in court, from 2010 to 2019 Muhammad owned and operated Happy Family Clinical Services LLC (Happy Family), a mental health and social services agency.

  From 2013 through 2019, Muhammad engaged in a scheme to defraud the Connecticut Medicaid Program by submitting fraudulent claims for psychotherapy services that were purportedly provided to Medicaid clients. The claims were for occasions and dates of service when no psychotherapy services of any kind had been provided to the Medicaid clients identified in the claims. The claims also were submitted using the names and identities of licensed clinical social workers and other licensed health care providers who purportedly worked for Happy Family, and represented that the psychotherapy services were personally rendered by the licensed providers, when, in fact, the licensed providers had not personally rendered the services, had not supervised the services that were billed, and were unaware that Muhammad was billing or causing the services to be billed as if the providers had personally rendered the services. When services were pro-vided, they were usually rendered by unlicensed individuals and billed as licensed psychotherapy

  This case was investigated by HHS-OIG and the Connecticut MFCU.

- **Dental Hygienist Practicing as Unlicensed Dentist Arrested for Medicaid Fraud**

  In March 2021, Julio Suarez, a dental hygienist, was arrested on charges of committing Medicaid fraud for illegally practicing as an unlicensed dentist. Suarez allegedly per-formed unlicensed and unauthorized procedures on patients, defrauding the Medicaid program out of more than $8,000.

  For more than 2 years, Suarez allegedly worked as an unlicensed dentist for Art Dental Services, Inc. While employed at Art Dental, Suarez knowingly performed unlicensed dental services and procedures on unwitting and unsuspecting patients. Suarez then billed the unlicensed services to the Medicaid program. By performing and billing these unlicensed dental procedures, Suarez fraudulently caused the Medicaid program to pay more than $8,000.

  Julio Suarez is charged with one count of Medicaid fraud, a second-degree felony and one count of grand theft, a third-degree felony. If convicted, Suarez faces up to 15 years in prison and $10,000 in fines.

  This case was investigated by the Florida MFCU.

- **Greensboro Corporate Officer Sentenced to 37 Months in Federal Prison for Medicaid Fraud:** In March 2021, Pamela Grace Faulkner of Greensboro, North Carolina, was sentenced to 37 months in Federal prison followed by 3 years of supervised release for conspiracy to commit health care fraud. Faulkner was also ordered to pay $213,928 in restitution.

  Faulkner was the sole officer of Skeen Services, Inc., which had offices in Greensboro, Greenville, Lumberton, and Wilson, North Carolina. With Faulkner's awareness, her co-conspirator Renee Christine Borunda submitted more than 4,500 fraudulent claims to Medicaid in 2013 and 2014. The claims falsely represented that more than 190 North Carolinians had received behavioral health services who in fact had not been provided. Faulkner and Borunda agreed to split the money from the reimbursements for these fraudulent claims. Medicaid paid Skeen Services approximately $213,928 for these false claims by electronically depositing the funds into an account that Faulkner controlled. Faulkner then paid Borunda approximately $144,000.

  Borunda was previously sentenced on November 7, 2018, to 37 months in Federal pris-on followed by 3 years of supervised release for conspiracy to commit health care fraud and aggravated identity theft.

  The investigation and prosecution of this case was conducted by the North Carolina Department of Justice's Medicaid Investigations Division, IRS-CI, and the United States Attorney's Office for the Eastern District of North Carolina.

Medical Identity Theft

- **North Texas Woman Guilty in Conspiracy to Possess and Use Means of Identification in a Multimillion-Dollar Scheme Involving the Sale of Forged Prescriptions:** In March 2021, Lydia Henslee, a Denison, Texas, woman pleaded guilty to conspiring to obtain information from a protected computer and conspiracy to unlawfully possess and use a means of identification. Her co-conspirators, Demetrius Cervantes and Amanda Lowry, previously pleaded guilty to conspiracy to obtain information from a protected computer.

  According to information presented in court, the defendants breached a health care provider's electronic health record (EHR) system in order to steal protected health information and personally identifiable information belonging to patients. This stolen information was then "repackaged" in the form of false and fraudulent physician orders and subsequently sold to durable medical equipment (DME) providers and contractors. Within approximately 8 months, the defendants obtained more the $1.4 million in proceeds from the sale of the stolen information. The proceeds of the offenses were traced to the following forfeitable assets: a 2019 Land Rover Range Rover Supercharged, a 2019 Dodge Durango SUV, a 2018 Polaris RZR XP4 1000 EPS, a 2019 Can-Am Out-lander 450, a 2019 Sea-Doo RXT-X 300 W, a 2019 Sea-Doo RXT-X 300 W, and a 2019 Karavan Sea-Doo Move.

  According to the superseding indictment, the defendants are alleged to have conspired to pay and receive kickbacks in exchange for orders from physicians that were subsequently used to obtain payments from Federal health care programs. The conspirators obtained patient information, including protected health information and personally identifiable information, and used the information to create fictitious physician orders. The conspirators then sold the physicians' orders to each other and to other DME providers. Within approximately 8 months, the defendants collectively obtained more than $2.9 million in proceeds from the criminal scheme.

  This case was investigated by HHS-OIG, the U.S. Department of the Treasury, IRS-CI, and the DOD-DCIS.

Medicare Part A | Hospitals

- **West Virginia Hospital Agrees to Pay More Than $300,000 for Medicare Fraud:** In February 2021, Grant Memorial Hospital in Petersburg, West Virginia, agreed to pay $320,176 for filing false claims to Medicare, Medicaid, TRICARE, VA, and Railroad Retirement Programs from September 2014 to March 2016. The claims were for outpatient and inpatient services and items using the National Provider Identifier number and name of a credentialed physician, when, in fact, the services and items were actually provided by a non-credentialed physician.

  The hospital disclosed the claims in February 2019, pursuant to the OIG-HHS self-disclosure protocol.

  Assistant U.S. Attorney Christopher J. Prezioso litigated the case on behalf of the government. Agencies involved in the investigation and settlement are HHS-OIG, the West Virginia Attorney General's Office, the West Virginia MFCU, the West Virginia Bureau for Medical Services, the Defense Health Agency for TRICARE, and the U.S. Department of Veterans Affairs (VA).

Medicare Part B | Patient Harm

- **Cardiologist Dinesh Shah Pays $2 Million To Resolve False Claims Act Allegations Relating To Excessive Testing:** In March 2021, an Oakland County Cardiologist, Dinesh M. Shah, M.D. and his practice, Michigan Physicians Group, P.C. (MPG) paid the United States $2 million to re-solve allegations that they violated the False Claims Act by knowingly billing Federal healthcare programs for diagnostic testing that was either unnecessary or not performed. MPG is a Michigan professional corporation with primary offices located in Berkley and Livonia, Michigan, and with administrative offices, labs, and testing sites at other locations within the metropolitan Detroit area. Shah is a practicing cardiologist and the sole owner of MPG.

  The settlement resolves allegations that from 2006 to 2017, Shah and MPG knowingly billed government programs, including Medicare, Medicaid, and TRICARE, for un-necessary diagnostic testing. The investigation focused on the provision of a group of diagnostic tests, which included Ankle Brachial Index and Toe Brachial Index tests, known as ABI/TBIs, which were routinely performed on patients without first being ordered by a physician and without regard to medical necessity. The ABI compares blood pressure in the ankle to blood pressure in the arm to determine how well blood is flowing from the heart to the feet. The TBI is an additional measure to assess blood pressure readings at the toes.

  The investigation also focused on the provision of unnecessary Nuclear Stress Tests. The United States alleged that Shah was routinely ordering, and MPG was providing, un-necessary Nuclear Stress Tests to some patients. During a Nuclear Stress Test, a small amount of radioactive tracer is injected into a vein, after which it is detected by a special camera that produces images used to evaluate blood flow to the heart.

  "Subjecting patients to unnecessary testing in order to fill one's pockets with taxpayer funds will not be tolerated. Such practices are particularly concerning because overuse of some tests can be harmful to patients," said Acting U.S. Attorney Saima Mohsin.

  The settlement resolves allegations originally brought in lawsuits filed under the qui tam, or whistleblower, provisions of the False Claims Act by two separate whistleblowers.

  This matter was investigated by HHS-OIG and the Defense Health Agency.

Medicare Part B

- **Civil and Criminal Healthcare Fraud Charges Brought Against Vascular Surgeon for Fraudulently Billing Medicare for Medically Unnecessary Procedures – Dr. Feng Qin Agrees to Pay $800,000, Admits Misconduct, and Receives Four-Year Ban from Participating in Federal Healthcare Programs:** In March 2021, the civil and criminal healthcare fraud cases against Feng Qin, M.D., a vascular surgeon, and his medical practice Qin Medical P.C. (Qin Medical) were re-solved under a civil settlement agreement. Under the civil settlement, Qin and Qin Medical agreed to a pay $783,200 to the United States. The State of New York is expected soon to enter into an additional settlement with defendants in the amount of $16,800, for a total recovery of $800,000. As part of the settlement, Qin and Qin Medical admit-ted and accepted responsibility for conduct alleged by the Government in its civil complaint.

  Qin also entered into a Voluntary Exclusion Agreement with HHS-OIG, which prohibits him from participating in Medicare and other Federal healthcare programs for 4 years. This is in addition to the more than two years he has been so excluded since his arrest, as a condition of his bail. The Government has agreed to defer Qin's criminal prosecution for a period of 1 year, after which time it will seek to dismiss the charges if Qin abides by the terms of the deferred prosecution agreement.

  Qin, who practiced in Lower Manhattan and Far Rockaway, Queens, was criminally charged in December 2018 with fraudulently billing Medicare for vascular surgery procedures performed on end-stage renal disease (ESRD) patients that were not medically reasonable and necessary or covered under Medicare rules.

  According to the indictment and the Government's civil complaint:

  - Patients with ESRD who are receiving dialysis may require vascular access surgical procedures, such as fistulagrams, where dye is injected into the patient's vein or artery to visualize blood flow, and percutaneous transluminal angioplasties, in which wires and balloons are inserted into blood vessels that have narrowed in order to restore blood flow. However, as Medicare billing guidelines made clear, it is not reasonable and necessary for physicians to bill the program for fistulagrams and angioplasties unless the patient has specific and documented clinical problems, such as significant difficulty receiving dialysis properly.
  - The patients at Qin's medical practice primarily consisted of ESRD patients undergoing dialysis treatment. During the relevant period, from 2015 to 2016, Qin routinely scheduled patients for fistulagrams and angioplasties three months in advance and performed fistulagrams and angioplasties on these patients as a matter of routine, regardless of whether there was a justifiable clinical reason to do so. Furthermore, on multiple occasions he misrepresented the medical conditions of patients in their medical records to make it seem as if they suffered from symptoms that would warrant the procedures when they did not. Qin Medical then unlawfully billed and received payment from Medicare for these procedures, which were excluded from Medicare coverage, as Qin knew.

  As part of the civil settlement, Qin and Qin Medical admitted, acknowledged, and accepted responsibility for the following conduct:

  - Qin often routinely scheduled, and actually saw, ESRD patients approximately every three months, regardless of their medical need.
  - Qin treated many of his ESRD patients with fistulagrams and angioplasties. The symptoms documented in the medical records, including the records of the dialysis center and the treating nephrologist, were insufficient to justify these treatments for numerous ESRD patients.

- Qin knew that in the absence of a documented clinical justification, Medicare would not pay for fistulagrams or angioplasties. Nevertheless, on numerous occasions, Qin Medical sought and received reimbursement from Medicare for these treatments without the required documented clinical justification.

The allegations of fraud stated in the civil complaint were first brought to the attention of Federal law enforcement by a whistleblower who filed a lawsuit under the False Claims Act.

This matter was investigated by HHS-OIG. The criminal case is being handled by the United States Attorney's Office for the Southern District of New York General, Crimes Unit. The civil case is being handled by the Office's Civil Frauds Unit.

- **Fort Worth Doctor Sentenced to 10 Years in Health Care Fraud Conspiracy:** In February 2021, Mark Kuper, a Fort Worth osteopath, who attempted to incinerate clinic records, was sentenced to 10 years in Federal prison for his role in a $10 million healthcare fraud scheme.

  Dr. Kuper, the owner of the Texas Center for Orthopedic and Spinal Disorders (TCOSD), was indicted in June 2020. Three months later, he pleaded guilty to one count of conspiracy to commit healthcare fraud.

  According to plea papers, Dr. Kuper admitted he conspired with his wife, Melissa Kuper, and a TCOSD physical therapist, Travis Couey, to defraud Medicare, Medicaid, and TRICARE.

  The defendant admitted he fraudulently billed insurers for services the clinic never actually rendered, including physical therapy and psychotherapy, and required patients to attend these bogus appointments in order to receive Schedule II controlled substance prescriptions.

  He also admitted that he gave his wife access to the secure device and passcode he used to sign controlled substance prescriptions, allowing her to improperly dispense pain medications on her own initiative, without his input.

  In plea papers, Dr. Kuper acknowledged that he submitted claims stating that TCOSD had developed individualized physical therapy plans of care for each patient, knowing full well that the clinic had simply issued a boilerplate template, and for one-on-one physical therapy, even though the patients were actually meeting in groups with an athletic trainer who was not qualified to perform physical therapy.

  Dr. Kuper further admitted that although he billed insurers for professional 60-minute psychotherapy sessions, most patients actually spoke with unqualified professionals for just 15 to 20 minutes–often when Dr. Kuper was out of the office.

  On multiple occasions, Dr. Kuper billed as though he'd provided more than 100 hours' work in a single 24-hour day. From 2014 to 2017, he submitted more than $10 million in claims to Medicaid, Medicare, and TRICARE.

  As the scheme unraveled, Ms. Kuper attempted to destroy TCOSD documents in an outdoor fireplace at their home. The blaze destroyed their residence, but firefighters were able to recover some of the charred records from the outdoor fireplace.

  Dr. Kuper also tried to cover up evidence of the fraud by accessing hundreds of electronic patient records and altering the purported treatment notes to make them appear more comprehensive.

  Both Ms. Kuper and Mr. Couey pleaded guilty in September 2020 to conspiracy to commit healthcare fraud. They were sentenced to 18 months and 36 months, respectively.

A civil investigation into TCOSD began after whistleblower Richard Brown filed a qui tam suit alleging that Dr. Kuper was committing fraud through his clinic. The Government's False Claims Act complaint alleged that Dr. Kuper submitted fraudulent claims for physical therapy, psychotherapy, and pain injection services to Federal healthcare programs.

In addition to his guilty plea, Dr. Kuper and his clinic agreed to settle the False Claims Act lawsuit by entry of an agreed judgment of approximately $11.2 million. As part of the settlement, Dr. Kuper also agreed to liquidate his real estate portfolio and other as-sets to satisfy the civil judgment. The whistleblower, Richard Brown, will receive 17% of the government's recovery.

This case was investigated by HHS-OIG, DOD-DCIS, and the Texas MFCU, with assistance from the DEA.

Mental / Behavioral Health

- **Ohio Treatment Facilities and Corporate Parent Agree to Pay $10.25 Million to Re-solve False Claims Act Allegations of Kickbacks to Patients and Unnecessary Admissions:** In March 2021, Oglethorpe Inc. and its three Ohio facilities, Cambridge Behavioral Hospital, Ridgeview Behavioral Hospital, and The Woods at Parkside, agreed to pay $10.25 million to resolve alleged violations of the False Claims Act for improperly providing free long-distance transportation to patients and admitting patients at Cam-bridge and Ridgeview who did not require inpatient psychiatric treatment, resulting in the submission of false claims to the Medicare program.

  Oglethorpe Inc. is a Florida company that operates two Ohio inpatient psychiatric hospitals, Cambridge and Ridgeview, and one Ohio substance abuse treatment facility, Parkside. The settlement was based on analysis of the companies' ability to pay after re-view of their financial condition.

  The settlement resolves allegations that, between August 2013 and June 2019, defend-ants provided free long-distance van transportation to patients to induce them to seek treatment at the defendants' facilities, in violation of the Anti-Kickback Statute, and then submitted claims for services provided to these patients, in violation of the False Claims Act. The government also alleged that Oglethorpe, Cambridge, and Ridgeview submitted, or caused to be submitted, false claims to Medicare for medically unnecessary inpatient psychiatric admissions and associated services at the two hospitals.

  The civil settlement includes the resolution of claims brought under the qui tam or whistleblower provisions of the False Claims Act by a former client advocate at Cambridge.

  This matter was investigated by HHS-OIG, the DOJ's Civil Division–Commercial Litigation Branch, and the U.S. Attorney's Office for the Southern District of Ohio.

- **Former Evansville Mental Health Counselor Sentenced for Submitting Over 2,000 Materially False and Fraudulent Claims to Medicaid and Medicare:** In March 2021, Barbara B. Witte, 74, of Evansville, Indiana, was convicted of felony health care fraud and sentenced to 2 years of Federal probation and ordered to pay $186,347 in restitution and a $50,000 fine. Witte was a licensed mental health counselor who provided counseling services for patients in Evansville and Vanderburgh County through her business, B-One Counseling. She billed health care benefit programs, including Medicaid and Medicare, for medical services she provided.

  Between January 2014 and July 2018, Witte submitted over 2,000 materially false and fraudulent claims to Medicaid and Medicare for mental health services that had not actually been provided to the patients identified in the claims. Medicaid and Medicare processed Witte's false claims and paid her for these services. Witte's conduct caused a loss of $146,334 to the Medicaid program, and $40,013 to the Medicare program.

  This case was investigated by HHS-OIG, the FBI, and the Indiana MFCU.

Pain Management

- **Pain Clinic Pays More Than $1.6 Million to Settle False Claims Act and Kickback Allegations:** In February 2021, Collier Anesthesia Pain, LLC, a pain management clinic located in Fort Myers, Florida, and Tampa Pain Relief Center, Inc., agreed to pay more than $1.6 million to resolve allegations that they violated the False Claims Act and Anti-Kickback Statute.

  As part of the settlement, the United States contends that Collier Anesthesia and Tampa Pain engaged in an illegal kickback scheme by causing affiliated surgery centers to waive copayments for surgical facility fees in order to induce patients to receive injection procedures. Additionally, the United States contends that Collier Anesthesia and Tampa Pain knowingly submitted false claims by improperly billing for evaluation and management services and psychological testing services.

  This settlement resulted from a coordinated effort by the U.S. Attorney's Office for the Middle District of Florida, HHS-OIG, the Defense Criminal Investigative Service (DCIS), and the U.S. Office of Personnel Management (OPM)–OIG.

Patient Harm

- **California Attorney General Sues Nursing Home Chain for Misrepresenting its Quality of Care and Putting Seniors, People with Disabilities at Risk:** In March 2021, the California Attorney General joined a coalition of District and City Attorneys in filing a lawsuit against Tennessee-based Brookdale Senior Living, Inc. (Brookdale), the nation's largest senior living operator. The lawsuit, which concerns Brookdale's ten California skilled nursing facilities, alleges that Brookdale ignored laws that protect patients' safety when they are discharged from a facility. The lawsuit also alleges that Brookdale gave false information to the Centers for Medicare & Medicaid (CMS), information which CMS uses to award "star ratings" to skilled nursing facilities so that consumers can choose a quality facility. By lying to CMS, Brookdale fraudulently increased its star rating in several categories to attract prospective patients and their families.

  The lawsuit alleges that Brookdale failed to properly notify its patients and families of transfers and discharges. Skilled nursing facilities are required to give notice of transfer or discharge at least 30 days in advance, or as soon as practicable. Brookdale failed to timely provide this required notice to its patients, with a copy to the local ombudsmen. Brookdale also failed to properly prepare its patients for transfer or discharge. As a result of these actions, Brookdale endangered the health of its patients and also left families scrambling to find other places to care for their loved ones.

According to court documents, residents illegally discharged from Brookdale facilities faced a range of harm, from stress and uncertainty in arranging alternate suitable care to life-threatening health crises. For example, Brookdale discharged a resident with little notice, no notice to the ombudsman, and no discharge planning. The resident's family members repeatedly asked Brookdale for help but were given none. The family finally located a facility on their own on the Internet. Another Brookdale resident who was discharged without the required notice or discharge planning was an 80-year-old man suffering from Alzheimer' s disease, congestive heart failure, chronic atrial fibrillation, chronic obstructive pulmonary disease, diabetes mellitus, and gastro esophageal reflux. Had Brookdale provided a discharge plan, it would have evaluated provision for his on-going care, including catheterization, careful feeding to prevent aspiration, and treatment of a stage 3 pressure ulcer. Within a week of discharge, he was admitted to an acute care hospital. In another case, Brookdale discharged a 78-year-old resident with impaired ambulation, heart disease and kidney disease, and who was recovering from pneumonia. This resident was also discharged without required notice to the resident, the family, or the ombudsman, and without a discharge plan. His family members were given no explanation about his medications, and were not trained to administer his oxy-gen. The resident was discharged with a Peripherally Inserted Central Catheter ("PI CC line"), a catheter used for intravenous medications, still attached to his body.

The lawsuit further alleged that Brookdale misrepresented the quality of its care to the public by reporting false information to CMS. As a means of helping the public to choose a skilled nursing facility, CMS rates facilities on several quality measures on a scale of one to five stars, which are then posted to the CMS website. The lawsuit alleges that Brookdale over-reported its nursing staffing hours to CMS, and by doing so, Brookdale was awarded undeserved four-and five-star ratings. In the lawsuit, the coalition argues that by engaging in these unfair business practices, Brookdale violated both the Unfair Competition Law and False Advertising Law.

Prescription Drugs

- **Pharmacist Sentenced to More Than 14 Years in Federal Prison for a Drug Distribution Conspiracy and for Murder for Hire – Defendant Ordered a “Hit” on the Person He Believed Had Cooperated with Law Enforcement Investigating his Drug Distribution Operation:** In March 2021, David Robinson of Baltimore, Maryland, was sentenced to 171 months in Federal prison, followed by 3 years of supervised release, for the Federal charges of conspiracy to distribute oxycodone and alprazolam, and for murder for hire.

  Robinson, formerly a licensed pharmacist who owned and operated the Frankford Family Pharmacy, pleaded guilty on October 10, 2018, to a Federal drug conspiracy involving the distribution of oxycodone and alprazolam outside the scope of professional practice and not for a legitimate medical purpose. On December 17, 2020, Robinson pleaded guilty to a Federal charge of murder for hire, admitting that he ordered a “hit” on the person he believed had cooperated with law enforcement that led to his indictment on those charges. Robinson’s pharmacist license was suspended on August 7, 2017.

  According to Robinson’s plea agreement for the drug distribution conspiracy, a confidential source (CS-1) advised law enforcement that the pharmacist at Frankford Family Pharmacy knowingly filled fraudulent prescriptions for alprazolam and oxycodone at the pharmacy. During the investigation, between January and July 2016, the confidential source made a number of controlled purchases from Robinson at the pharmacy, using blank prescriptions provided to the source by law enforcement agents. Robinson knew that the prescriptions were fraudulent because he told the confidential source what name to use on the prescriptions and what quantity of oxycodone tablets to write on the prescriptions. Robinson also told the source to include non-controlled medications on the same prescriptions in order to evade law enforcement. Between April 2015 and June 2017, Robinson fraudulently distributed approximately 12,330 units of alprazolam and 10,000 milligrams of oxycodone.

Federal investigators also learned that during Robinson's tenure as a pharmacist working the night shift at a pharmacy in Waldorf, Maryland, Robinson also filled fraudulent prescriptions for oxycodone. Robinson admitted that he wrote prescriptions using the names of prominent athletes provided to him as the purported patients. Between September and December 2015, Robinson admitted that he dispensed at least 85,500 milli-grams of oxycodone outside the scope of professional practice and not for a legitimate medical purpose.

On October 27, 2018, Baltimore City's Citi-Watch camera system captured a drug transaction, which led to the arrest of an individual, CS-2. A search of CS-2's vehicle resulted in the recovery of two shoeboxes containing a total of 35 stock pharmacy bottles of the prescription medications promethazine and clonidine.

CS-2 had obtained the prescription medications from David Robinson. CS-2 had known Robinson for approximately 3 years, and had previously purchased oxycodone, Xanax, clonidine, and promethazine from Robinson at the Frankford Family Pharmacy. After the search warrant was executed at Robinson's pharmacy on June 27, 2017, Robinson began providing CS-2 with boxes of medications in exchange for cash without requiring a prescription. Robinson continued to sell promethazine and clonidine and six months after the raid, Robinson was still ordering pills from his vendors.

As detailed in his plea agreement for the murder for hire, following his arrest in 2017, Robinson told CS-2 about an individual that Robinson believed had cooperated with law enforcement and led to his arrest (i.e., CS-1). CS-2 and Robinson had a discussion about CS-1 being killed. After some time, the two agreed to have CS-1 killed. Robinson provided CS-2 with some information about CS-1. CS-2 told Robinson that he/she knew someone that could do a "hit" on CS-1. CS-2 told Robinson that the fee would be $5,000 up front and $5,000 when CS-l was killed.

Robinson admitted that from December 13, 2018 through February 7, 2019, CS-2 made three controlled purchases of drugs from Robinson, at the direction of law enforcement, using cash provided by DEA agents. CS-2 purchased a total of 118 stock pharmacy bottles of clonidine, each containing 100 tablets; and 24 stock pharmacy bottles of 50 mg promethazine tablets, with each bottle containing 100 tablets. Robinson did not request, nor did CS-2 provide, a prescription for any of the drugs.

During a controlled purchase on January 24, 2019, CS-2 and Robinson discussed the murder of CS-1 (which was audio-recorded). During this conversation, they discussed a $5,000 fee that had already been paid to the hitman, and that an associate of the hitman had information about the location of CS-1. The associate wanted an additional $3,000 to be paid to him/her in order to provide CS-1's location to the hitman. Robinson was upset over this additional fee required to identify the location and accomplish the murder of CS-1 and did not agree to pay the additional fee. On February 4, 2019, CS-2 sent a text message to Robinson's cell phone advising that he had provided the additional $3,000 in order to obtain CS-1's address.

On February 14, 2019, CS-2 called Robinson and told Robinson that the murder was done, and that the hitman would want his money. CS-2 then met with Robinson, who provided CS-2 with $2,000. CS-2 put the cash in his pocket and Robinson asked CS-2 for proof that the murder had been completed. CS-2 showed Robinson several fake photos in which it appeared that CS-l had been bound with zip ties, shot several times, and killed. After the meeting, law enforcement arrested Robinson.

The DEA, HHS-OIG, the Baltimore Police Department, and the Maryland Department of Public Safety and Correctional Services investigated this matter.

- **Judge Sentences "Doctors on the Go" Owner to 9 Years in Prison for Fraud and Receiving Kickbacks:** In February 2021, Denis Mikhlin was sentenced to 108 months in prison and ordered to pay restitution for causing the Medicare and Medicaid programs to pay over $4.7 mil-lion for medically unnecessary prescription drugs and drug tests.

  The 41-year-old St. Louis County, Missouri, resident pleaded guilty in August 2020 to four felony counts of conspiracy, obtaining oxycodone and other opioid drugs by fraud and deceit, and receiving illegal kickbacks in return for sending urine specimens to Central Diagnostic Laboratory for medically unnecessary testing.

  Mikhlin conspired with Dr. Jerry Leech and others to issue and distribute illegal prescriptions for opioids and other controlled substances to patients. Mikhlin and his co-conspirators knew the patients did not have a legitimate medical need for drugs and in-stead were abusing the drugs or selling them.

  Additionally, Mikhlin recruited individuals and paid them for the use of their names on the fraudulent prescriptions. Once the prescriptions were filled, some of the drugs were returned to Mikhlin and the rest were kept by the individuals or sold to others. To conceal this illegal activity, Mikhlin and others created patient files, falsely indicating the patients had been examined by the prescribing doctors and the patients were regularly monitored and tested.

  This case was investigated by HHS-OIG, the FBI, the Missouri Medicaid Fraud Control Unit (MFCU), and the U.S. Department of Defense (DOD).

- **Pharmacy Owner and Accountant Indicted in $134 Million Health Care Fraud Scheme:** In March 2021, authorities arrested Mohamed Mokbel and Fathy Elsafty both of Houston, Texas, on charges of conspiracy to commit health care fraud relating to a pharmacy fraud scheme. The Mokbel is the owner of several Houston area pharmacies and Elsafty is his accountant.

  4M Pharmaceuticals Inc. was the parent company for several retail pharmacies that operated in Houston, Fort Worth, South Florida, and elsewhere. Mokbel was 4M's CEO and allegedly had ownership interests in the subsidiary pharmacies. The charges allege Elsafty served as 4M's accountant and tax preparer as well as nominee owner of the multiple pharmacies.

  4M Pharmaceuticals allegedly functioned as an outbound telemarketing call center that solicited Medicare, Medicaid, and commercial insurance patients nationwide—many over the over the age of 55. The indictment alleges call center employees offered patients medically unnecessary diabetic supplies and topical creams although many refused the solicitations. However, 4M Pharmaceuticals and pharmacies allegedly billed the patient's insurance plan anyway. In some cases, 4M pharmacies billed for prescriptions dispensed after a patient's death, according to the allegations.

  The scheme also allegedly targeted doctors. The charges allege 4M Pharmaceuticals sent fax requests for prescriptions that patients often did not authorize. In several cases, the company billed patients for prescription drugs without a valid prescription. 4M pharmacies also allegedly sent prescription requests to doctors for dead patients.

  In several instances, audits required 4M to produce paperwork and Elsafty allegedly participated in fabricating records.

  The indictment alleges that from December 13, 2013, through March 3, 2020, 4M pharmacies collectively received over $134 million in payments from Medicare and other healthcare benefit programs based on fraudulent claims. The funds were allegedly used, in part, to pay for Mokbel's $1.5 million residence, $15 million in gambling and casino expenses and purchases and payments for a Ferrari and a Bentley automobile. Mokbel also transferred and controlled over $6 million in health care fraud proceeds in certificate of deposit accounts at banks.

This investigation was conducted by HHS-OIG, Immigration and Customs Enforcement (ICE), the Food and Drug Administration–Office of Criminal Investigations (FDA-OCI), the FBI, the Texas MFCU, the Internal Revenue Service–Criminal Investigation (IRS-CI), the Ohio MFCU, and the Texas State Board of Pharmacy.

- **Israeli National Sentenced to 30 Months in Prison for Bail Jumping and Participating in Conspiracy to Distribute Unlicensed Prescription Drugs:** On April 1, 2021, Boaz BenMoshe, of Israel, was sentenced to 30 months in Federal prison for bail jumping and participating in a conspiracy to engage in the unlicensed wholesale distribution of prescription drugs.

  According to court documents and statements made in court, in November 2006, a Federal grand jury charged BenMoshe with conspiracy to launder monetary instruments and conspiracy to engage in unlicensed wholesale distribution of prescription drugs. Members of the conspiracy unlawfully purchased Serostrim (a drug for HIV and AIDS patients) from patients and then re-sold the drugs to wholesale drug distributors at a high profit. As part of the conspiracy, the group created false drug pedigrees that suggested that the drugs had been obtained through legitimate distributors.

  After an initial appearance hearing in California on January 29, 2007, BenMoshe was re-leased on conditions including his promise to notify the pretrial services officer of any plans to change his residence and to travel outside of the Central District of California and the District of New Hampshire.

  On January 9, 2009, BenMoshe pleaded guilty to conspiracy to engage in unlicensed wholesale distribution of prescription drugs. The Court accepted his guilty plea and permitted him to continue on the same conditions of release pending sentencing. The sentencing hearing was scheduled for June 23, 2009. On or about April 29, 2009, in violation of his conditions of release, BenMoshe moved to Israel and failed to appear for his sentencing hearing on June 23, 2009.

  On December 16, 2009, a Federal grand jury charged BenMoshe with bail jumping for his failure to appear at his sentencing hearing. In August 2020, BenMoshe was extradited from Israel to the United States to face the charges pending against him in New Hampshire. He pleaded guilty to the bail jumping charge on January 27, 2021.

  The Court sentenced BenMoshe to 18 months in prison for the conspiracy offense and an additional 12 months for the bail jumping offense. He will receive credit for the time he has been in custody prior to sentencing.

  The bail jumping matter was investigated by the U.S. Marshals Service. The underlying criminal case was investigated by FDA-OCI, HHS-OIG, and IRS-CI.

P-STIM

- **Texas Company Agrees to Reimburse Medicare for Improper Billing Related to Neurostimulators:** In January 2021, Spinal Decompression Clinic of Texas (SDCT) agreed to pay $330,898 to resolve liability under the False Claims Act for the alleged improper billing of electro- acupuncture device neurostimulators.

  From August 21, 2018 through June 26, 2019, SDCT billed Medicare for the implantation of 41 neurostimulators—a surgical procedure which usually requires an operating room and is reimbursed by Federal healthcare programs. SDCT received reimbursement from Medicare in the amount of $177,051 for these procedures. SDCT, however, did not perform these surgeries, and instead applied P-Stim devices in an office setting, without surgery or anesthesia. Medicare does not reimburse for acupuncture or for acupuncture devices such as P-Stim, nor does Medicare reimburse for P-Stim as a neurostimulator or as implantation of neurostimulator electrodes.

  This case was investigated by HHS-OIG.

- **Chiropractor Charged with Falsely Billing for Procedure Learned via YouTube:** In March 2021, Suhyun An, a Houston, Texas, chiropractor, and her medical group were named in a civil suit under the False Claims Act alleging fraudulent billing. An owns and manages Campbell Medical Group PLLC and Johnson Medical Group PLLC dba Campbell Medical Clinic in the Spring Valley area of Houston.

  The civil complaint alleges An fraudulently obtained over $3.9 million from the Medi-care and TRICARE programs by billing for the implantation of neurostimulator electrodes. These are surgical procedures usually requiring use of an operating room, and Medicare pays thousands of dollars for this procedure.

  The complaint alleges that neither An nor her clinic's employees performed surgery. In-stead, they allegedly applied inexpensive devices used for electro-acupuncture. This procedure involves inserting needles into patients' ears with a neurostimulator taped be-hind the ears with an adhesive.

  The lawsuit alleges nurse practitioners working for An learned how to apply the devices by watching YouTube videos and participating in trainings with sales representatives.

  The complaint alleges An knew the devices were not billable or recklessly disregarded that fact. She allegedly read specific guidance from a Medicare contractor stating Medi-care did not cover the devices because they only provided acupuncture. The suit further claims she ignored emailed warnings from employees and outside billing companies including warnings that the devices were being labeled as "possible fraud."

  This case was investigated by HHS-OIG.

Telemedicine

- **Burlington County Doctor Sentenced to 33 Months in Prison for Role in $24 Million Telemedicine Compounded Medication Scheme:** In January 2021, Bernard Ogon, a Burlington County, New Jersey, doctor was sentenced to 33 months in prison for his role in a telemedicine scheme to prescribe expensive compounded medications to patients who did not need them.

  According to documents filed in this case and statements made in court, Ogon admit-ted he signed prescriptions for compounded medications (medications with ingredients of a drug tailored to the needs of a particular patient) without having established a doc-tor-patient relationship, spoken to the patient or conducted any medical evaluation. Ogon often signed preprinted prescription forms—with patient information and medication already filled out—where all that was required was his signature. Then, instead of providing the prescription to the patient, Ogon would return the prescriptions to specific compounding pharmacies involved in the conspiracy. Ogon was paid $20 to $30 for each prescription he signed, and his participation in the conspiracy caused losses to health care benefit programs of over $24 million, including losses to government health care programs of over $7 million.

  In addition to the prison term, Ogon was sentenced to 3 years of supervised release and ordered to pay restitution of $24.3 million and forfeiture of $75,000.

  This case was investigated by HHS-OIG, the FBI, and DOD-DCIS.

- **Patient Recruiter Convicted in $2.8 Million Telemedicine Scheme Against Medicare:** In January 2021, Ivan Andre Scott, the owner of an Orlando-area telemarketing call center was convicted for his role in a kickback scheme involving expensive genetic tests and fraudulent telemedicine services that resulted in the payment of approximately $2.8 million in false and fraudulent claims to Medicare.

  According to evidence presented at trial showed that Scott targeted Medicare beneficiaries with telemarketing phone calls falsely stating that Medicare covered expensive cancer screening genetic testing, or “CGx.” The tests could cost as much as $6,000 per test. After beneficiaries agreed to take the test, the evidence showed Scott paid bribes and kickbacks to telemedicine companies to obtain doctor’s orders authorizing the tests.

  The evidence showed that the telemedicine doctors approved the expensive testing even though they were not treating the beneficiary for cancer or symptoms of cancer, and often without even speaking with the beneficiary. According to the evidence presented at trial, Scott then sold the genetic tests and doctor’s orders to laboratories in exchange for illegal kickbacks. To conceal the illegal kickbacks, Scott submitted invoices to the laboratories and other marketers making it appears as though he were being paid for hourly marketing services, rather than per referral.

  Between November 2018 and May 2019, labs submitted more than $2.8 million in claims to Medicare for genetic tests Scott referred to them, of which Medicare paid over $880,000. In that timeframe, Scott personally received approximately $180,000 for his role in the scheme.

  This case was investigated by HHS-OIG and the FBI and was brought as part of Operation Double Helix, a Federal law enforcement action led by the Health Care Fraud Strike Force.

Other enforcement activities can be found at the following site:
https://oig.hhs.gov/fraud/enforcement/criminal/index.asp.

Recent Medicaid enforcement activities can be found at the following site:
https://oig.hhs.gov/fraud/enforcement/state/index.asp.

Trends

Defense Health Agency

Key 2020 Risk Assessment Program Risks, based on recent historical trends:

- Applied Behavioral Analysis (ABA) - Impossible Days & RBTs performing service and billing under BCBA.
- Excessive Opioids/Potentiators Prescribers - Beneficiaries with high MME linking to prescribers.
- Telemedicine & Related Ancillary Costs (RX, DME, ABA, Labs, etc.).
- Laboratory and Durable Medical Equipment Orders - Without a valid patient provider relationship.
- Compound Drugs - Foot Baths.
- Skilled Nursing Facilities - Upcoding Therapy Resource Utilization Groups.
- Acute Hospitals - Referring providers focusing on Physician Groups - Orthopedic and Cardiology.

FBI

COVID-19 Related:

- The Federal Bureau of Investigation (FBI) has identified multiple health care fraud schemes by bad actors seeking to take advantage of the currently overburdened health care system and the public's fear over the COVID-19 pandemic. These fraud schemes target both government and private health insurers as well as private individuals and capitalize on the currently overburdened healthcare system to commit traditional health care fraud schemes such as overbilling, upcoding, unbundling of services, and billing for services not provided and/or which were not medically necessary. As of 7 April 2020, some of the more prevalent health care fraud-related schemes identified by the FBI are as follows:
    - Fraud actors are engaging in schemes to obtain and exploit individuals' identity information, including their insurance information (PII), and personal health information (PHI). The FBI has identified fraud schemes involving robo-callers who promote or offer "free" test kits, fake cures or drugs that allegedly offer protection against COVID-19, in exchange for PII or cash.
    - Fraudsters are also obtaining information and identifying potentially vulnerable targets from social media posts where someone discusses symptoms, health status or frustrations over treatment and testing. Fraudsters use this information to obtain PPI and PHI that is later used in fraudulent billing schemes or selling medically unnecessary and fake cures or protection from the virus to the unsuspecting and vulnerable public.
    - Calls and home visits offering telemedicine consultations for COVID-19 are also on the rise, with bad actors soliciting insurance information, most notably Medicare ID numbers and/or other PPI like driver license information.
    - Health care providers have also been paying kickbacks to marketers (recruiters) in exchange for patient referrals, services such as promoting/selling fake COVID-19 test kits, supplies and equipment, and for signing/forging prescriptions that are medically unnecessary/outside the normal bounds of medical practice.

- The FBI has also noted scammers creating fake shops, websites, social media accounts, and email addresses claiming to sell medical supplies currently in high demand and in short supply such as N-95 respirator masks, gloves, and other personal protective equipment (PPE). In these scams, suppliers solicit money up front, pocketing the money without providing the supplies.
- There has been an uptick in prescribing of hydroxychloroquine, an anti-malaria drug being touted as a potential cure for COVID-19. The FBI is aware some physicians are prescribing hydroxychloroquine for themselves and their families without medical necessity. This has resulted in short supplies with adverse consequences for those who need the drug for lupus, rheumatoid arthritis, and other chronic conditions.

Non-COVID-19 Related:

- The Federal Bureau of Investigation (FBI) has identified a scheme in which fraud actors create and sell fraudulent home health care aide training certifications to individuals who have not completed the required training hours prior to working as a home health care aide. The number of hours required by states for home health care aides varies, but all states require at least the federal 75-hour minimum training requirement. Home health aides who are caring for patients without the required training could put the health and well-being of patients at risk and could lead to home health agencies unintentionally or intentionally billing government and private health insurers for services provided by untrained and uncertified individuals.

HHS-OIG

- **Ambulance Transportation:** OIG continues to investigate cases in which ambulance providers misrepresent patient conditions and then obtain fraudulent Medicare payments for transport. Often, the transportation is medically unnecessary and/or the charges are upcoded. Swapping arrangements between medical institutions and ambulance companies also continue to be an area of concern throughout the ambulance industry.

- **CARES Act:** The Coronavirus Aid, Relief, and Economic Security (CARES) Act is designed to provide emergency financial assistance to millions of Americans who are suffering the economic effects resulting from the COVID-19 pandemic. One source of relief provided by the CARES Act is the Provider Relief Fund (PRF), which is intended to support American families, workers, and health care providers in the battle against the COVID-19 outbreak. The funding is provided by general and targeted distributions. A portion of the funding is meant to be distributed to health care providers who provide treatment for uninsured COVID-19 patients (Uninsured Portal/UP).

  HHS-OIG has identified fraud schemes where providers are not verifying that patients actually have health insurance and are billing those individuals as uninsured, billing add-on respiratory pathogen panels to the COVID-19 tests (unnecessary) to increase reimbursement, performing antibody tests and advertising those tests as rapid COVID-19 tests, and performing COVID-19 tests and submitting claims through the program but never providing the patient with test results.

  While collaborating with the Health Resources and Services Administration (HRSA), Our investigative priority is to ensure that the allotted funding is being utilized for its intended purpose.

  For more information related to the Provider Relief Fund and the Uninsured Portal, please see the following:

  - Provider Relief Fund: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html
    - Program Information, Terms and Conditions, and FAQs (ongoing updates)
  - Uninsured Portal: https://www.hrsa.gov/coviduninsuredclaim
    - Program Information and Requirements

- **Community Mental Health Centers:** OIG is investigating cases where CMHCs bill Medicare/Medicaid for services not pro-vided and for services provided by non-licensed individuals. OIG investigations also continue to identify scenarios where CMHCs bill for mental health services but instead provide, at best, recreational adult day care. This not only clogs the system for those in need of legitimate care but could also drive up overall health care costs. As mental health services are expanding under the Affordable Care Act, the task of rooting out fraud, waste, and abuse will only become more vital.

- **COVID-19:** OIG continues to see an uptick in hotline complaints regarding COVID-19-related fraud schemes. OIG and its law enforcement partners have investigated a steady stream of allegations of COVID-19-related fraud and abuse. Fraudsters are using telemarketing, text messages, social media platforms, and door-to-door visits to perpetrate scams to steal money and personal information from vulnerable people, exploiting fear and confusion. Fraudsters are offering COVID-19 test, COVID-19 vaccines, HHS grants, and Medicare prescription cards in exchange for personal details, including Medicare information. These services are unapproved and illegitimate. OIG remains vigilant and committed to holding perpetrators of fraud schemes accountable.

  OIG has alerted the public to suspicious activity related to vaccines, including:

  - requests for payment to get a vaccine, including deposits or fees;
  - requests for payment or offers of money to enhance ranking for vaccine eligibility (i.e., getting a better spot in line or on a wait list);
  - offers to sell or ship doses of vaccine for payment; and
  - offers to purchase vaccine record cards containing personally identifiable information and offers of money to participate in a vaccine survey.

- **Durable Medical Equipment:** OIG continues to investigate cases involving telemarketers contacting Medicare beneficiaries for DME providers. These telemarketers use mis-leading techniques to obtain Medicare beneficiary information. Some telemarketers may offer something for free in exchange for beneficiaries providing their personal and Medicare information. Once this information is obtained, the DME provider often bills for DME that is medically unnecessary or never provided. This telemarketing is used for several types of DME, including diabetic testing supplies and orthotics. OIG has also seen an increase in cases involving prosthetics that are medically unnecessary and/or never provided, and cases involving the fraudulent billing for repairs of power mobility devices.

- **Genetic Testing:** Data shows that genetic testing billing continues to be in the billions of dollars and growing. While there are increasing legitimate uses for genetic testing, there are also increasing fraud cases. For example, OIG is seeing testing performed for diseases the patient could not possibly have, including those that would not first appear in an older Medicare population, such as obvious birth defects.

  Unscrupulous labs are inserting themselves into health fairs, church events, or senior living centers to market their products and/or obtain a saliva swab sample from Medicare beneficiaries. The swab sample is obtained first, then the lab finds someone to approve the test. Often the signing provider for the genetic test is not the patient's treating physician and approval is obtained via telemedicine without an in-person encounter, medical necessity, or any prior patient-provider relationship.

Copays for the test are typically waived as a means of incentivizing the patient into participating. In some instances, the aggregated waived copays for these tests can amount to hundreds or thousands of dollars. Patients are told these tests are “at no cost to you”; however, if insurance denies the claim, the beneficiary is responsible to pay thousands of dollars out of pocket.

Genetic testing fraud alert. OIG issued a fraud alert for consumers on June 3, 2019. The fraud alert can be viewed at: https://oig.hhs.gov/fraud/consumer-alerts/alerts/geneticscam.asp.

- **Home Health:** A large number of home health fraud schemes investigated by OIG often involve kickbacks being paid to patients, patient recruiters, ordering physicians, and other healthcare providers. In some areas of the country, fraudulent home health providers are utilizing very aggressive recruiting techniques to solicit patients. Once a patient is recruited, the agency then sends a referral to a physician who signs the paperwork without first seeing the patient. Commonly, these same patients actually have primary care physicians who aren’t aware they are receiving home health. In addition, Medicare is being billed for patients who are not confined to the home in a large number of home health fraud schemes investigated by OIG.

- **Hospice Services:** OIG continues to see fraud related to hospice providers. These cases often involve fraudulently certifying patients as eligible for hospice services when they are not. OIG also continues to see hospice providers billing for a higher level of care for patients who do not need it and did not receive it. Hospice fraud schemes frequently also involve kickbacks to beneficiaries and health care providers alike. Hospice providers are also utilizing aggressive marketing techniques to solicit beneficiaries.

- **Medicaid:** As a result of the public health emergency (PHE), various legal authorities grant States emergency flexibilities critical to ensuring that States can respond to the crisis expeditiously to protect and serve the general public. Over the course of the COVID-19 PHE, State Medicaid and CHIP agencies adopted many flexibilities offered by CMS to respond effectively to their local outbreaks.

  To support health care delivery while minimizing face-to-face encounters during the COVID-19 PHE, many states accelerated adoption of services provided by telehealth, across a wide variety of disciplines.

  We continue to identify bad actors who have taken advantage of additional telehealth flexibilities by billing for items and services that were not rendered or medically necessary.

  Appearing below are fraud trends that OIG continues to see as areas of concern in the Medicaid space.

  - *COVID-19 Death Diagnosis within Medicaid*—OIG is monitoring providers and States for possible reclassifying of COVID-19 death diagnoses due to increased reimbursements.
  - *Administration of payments to providers within Medicaid*—Based on emerging trends, States appear to be increasingly vulnerable to hackers changing Payment/Electronic Funds Transfer (EFT) forms. Two-factor authentication is not utilized when changing payment accounts for providers. It is for this reason that WA, IA, TX, OH and more States have been affected.
  - *Community Mental Centers or Psychosocial Rehabilitation*—There are potentially 300 subjects in Maim-Dade County involved in this type of fraud with close to 1 billion paid in 2020.
  - *Cases involving mental health counselors and their billing of individual psychotherapy*—Listed below are summaries of what we are seeing:

- Non-supervisory counselors—i.e., counselors who do not have the requisite license to supervise other counselors—claiming to be supervisors and hiring counselors or counselor interns. All claims that are submitted for services rendered by employees have the employer's NPI number;
- Individual psychotherapy claimed for beneficiaries receiving group therapy for summer or after school programs, such as basketball camp and military-style boot camp; and
- Providers obtaining the PII of all the siblings and children of a family and then billing all members of the family for psychotherapy services even though only one child is receiving treatment.

- **Medical Identity Theft:** Although OIG has seen an increase in the involvement of organized crime entities who utilize stolen or compromised beneficiary and provider identities, medical identity theft can also be carried out by healthcare providers and other individuals who have access to patient records and personally identifiable information. Cyberintrusions and new challenges that Electronic Health Records may pose to the protection of beneficiaries' personal health information are also elements that can factor into the increase in medical identity theft. OIG recognizes the increased risk identity theft poses to our Medi-care and Medicaid beneficiaries and providers and will continue to actively investigate allegations and instances of medical identity theft related to Medicare and Medicaid fraud.

- **Medicare Part C / Medicare Managed Care:** OIG continues to see an increase with the Medicare Part C investigations involving risk adjustment fraud. These cases involve Medicare Advantage plans submitting risk-adjustment payments for medical conditions that their members were not treated for and may not even have. These investigations also involve upcoding members' diagnoses to exaggerate the severity of the members' condition, in order to submit a diagnosis code that triggers a higher risk adjustment score. In addition, OIG is working jointly with SSA to investigate individuals who are receiving disability benefits fraudulent and have enrolled in Part C plans. As a result of their fraudulent disability benefits, these individuals gain eligibility into the Medicare program, and enroll in various Medicare Advantage plans to receive medical coverage.

- **Pharmaceutical:** OIG continues to monitor opioid use. During the pandemic, there have not been major spikes. However, with telehealth widely available, OIG continues to monitor for inappropriate opioid prescribing using this modality.

  OIG continues to be in partnership with CDC and HHS Office of Assistant Secretary, and DEA. As illicit prescribers are taken out of the mix, innocent patients with real pain syndromes and addiction issues can be suddenly left in withdrawal. To circumvent such scenarios, the Opioid Rapid Response Program partners with State entities to provide assistance to patients immediately during and after joint Federal law enforcement efforts to provide a warm hand-off to ongoing, but legitimate, care.

  Vaccine frauds during the pandemic continue to be common. Often, fraudsters offer vaccines that do not exist or cause the patient to be victims of identity theft and other Medicare frauds for medically unnecessary tests, medications, and DME supplies.

- **Telehealth:** As OIG has seen increased activity related to "telefraud" schemes, it is important to distinguish those schemes from telehealth fraud. In the last few years, OIG has con-ducted several large investigations of fraud schemes that inappropriately leveraged the reach of telemarketing schemes in combination with unscrupulous doctors conducting sham remote visits to increase the size and scale of the perpetrator's criminal operations. In many cases, the criminals did not bill for the sham telehealth visit. Instead, the perpetrators billed fraudulently for other items or services, like durable medical equipment or genetic tests. OIG will continue to vigilantly pursue these "telefraud" schemes and monitor the evolution of scams that may relate to telehealth.

Agency Statistics

CMS Statistics

- CMS's provider screening and enrollment efforts in Medicare have had a significant impact on removing ineligible providers and suppliers from the program. In FY 2018, CMS deactivated over 158,000 enrollments and revoked about 1,950 enrollments.

- The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary, public-private partnership between the Federal Government, state and local agencies, law enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations to identify and reduce fraud, waste, and abuse across the healthcare sector. The HFPP is currently made up of 168 members: 79 Private Payers, 44 State & local partners, 27 Law enforcement, 13 Associations, and 5 Federal partners. The HFPP currently receives data on 104 million individuals with insurance, but our potential is even greater. Currently, the HFPP reviews data on 1 in 3 Americans; the partnership's potential goal expands to 3 in 4 Americans.

- In April 2018, CMS created a law enforcement partnership forum, the Major Case Coordination (MCC), designed so that CMS and law enforcement partners can quickly and systematically collaborate on fraud health care schemes. Through this collaboration, CMS is able to maximize efforts to identify, investigate, and pursue providers who might otherwise endanger program beneficiaries or commit fraud on federal programs. The goal of the MCC process is to ensure the right tool (CMS's administrative tools vs law enforcement tactics) is applied to the right case, at the right time (to not interfere with sensitive law enforcement operations) and in the right order. CMS's efforts to identify potential fraud earlier in the process have resulted in numerous successful takedowns, marked increases in number and amount of charged health care cases and hundreds of millions of dollars in increased savings related to administrative enforcement actions. As a result of these efforts, CMS achieved the following:

    - FY 2018 to FY 2019, nearly doubled total Medicare revocation savings through the revocation of bad actor billing privileges.
    - FY 2018 to FY 2019, doubled Medicare savings from law enforcement referrals.
    - In FY19, CMS investigated the largest number of cases through its first-of-its-kind healthcare fraud case coordination process with OIG, DOJ, OCIG. Over 1000 cases (25% increase from 2018) were reviewed.
    - Most and largest nationwide law enforcement takedowns ever:
        - Operation Brace Yourself: 24 individuals charged - $1.2 billion in losses – administrative action against 130 DME companies for over $1.7 billion in claims submitted.
        - Operation Double Helix: 35 individuals charged – $2.1 billion in losses – suspended 11 clinical laboratories. CMS proactively identified, deactivated, and reissued 220,000 Medicare Beneficiary Identifier (MBI) numbers on the new Medicare card that were compromised in nationwide fraud schemes. This safeguard effort prevented an estimated $1.1 billion that could have been at risk to the Medicare program.

Defense Health Agency Statistics

- 875 investigative cases were actively managed.
- 329 new cases were opened.
- 353 cases were closed.
- 1,485 leads/requests for assistance were responded to TRICARE judgments and settlements for calendar year 2019 totaled $125,905,105.
- CY 2019 prepayment duplicate denials amounted to $594,743,871.

HHS-OIG-OI Fiscal Year-To-Date Statistics (Quarterly)

- For the fiscal year-to-date ending March 31, 2021*, we reported 213 criminal and 193 civil and Civil Monetary Penalty Law actions against individuals or entities that engaged in health-care-related offenses. We also reported $729.98 million in HHS investigative receivables and $544.57 million in non-HHS investigative receivables (such as from our work related to the States' share of Medicaid restitution) for a total of $1.24 billion in total healthcare-related investigative receivables.

  Such receivables, which represent expected recoveries, result from civil and administrative settlements or civil judgments related to Medicare, Medicaid, and other Federal, State, and private health care programs.

  **Please note that the above reported numbers represent the 2nd quarter for fiscal year 2021.*

HHS-OIG Statistics (Recent)

- Additional information regarding HHS-OIG statistics can be found in the Semi-Annual Report (SAR) to Congress. The SAR describes OIG's work identifying significant risks, abuses, deficiencies, remedies, and investigative outcomes related to HHS programs and operations during the 6-month periods ending March 31 and September 30. Semiannual reports are intended to keep the Secretary and the Congress fully and currently informed of significant findings and recommendations by OIG.
- Additional information regarding law enforcement statistics and activities regarding health care fraud and abuse can be found in the Health Care Fraud Abuse and Control Program Report.

Sanctions, Debarments, Suspensions

HHS-OIG Exclusions from Participation in Federal Health Care Programs

- OIG has the authority to exclude individuals and entities from Federally funded health care programs pursuant to sections 1128 and 1156 of the Social Security Act and maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals and Entities (LEIE). The effects of an exclusion are outlined in the *Updated Special Advisory Bulletin on the Effect of Exclusions From Participation in Federal Health Programs*, but the primary effect is that no payment will be provided for any items or services furnished, ordered, or pre-scribed by an excluded individual or entity. This includes Medicare, Medicaid, and all other Federal plans and programs that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan).

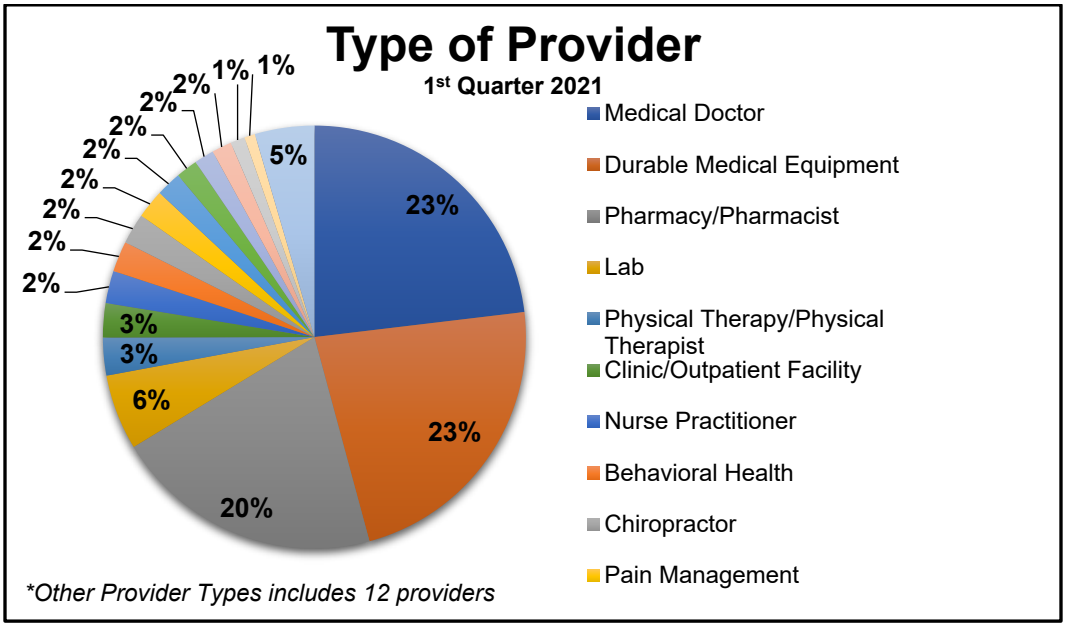
- Exclusions: For the fiscal year-to-date ending March 31, 2021*, OIG excluded 1036 entities from participation in Federal health care programs.

    - Searchable exclusion lists are available on OIG's Web site at: https://exclusions.oig.hhs.gov/.
    - Additional information regarding exclusions to include Special Advisory Bulletins and other guidance can be found at: https://oig.hhs.gov/exclusions/index.asp.

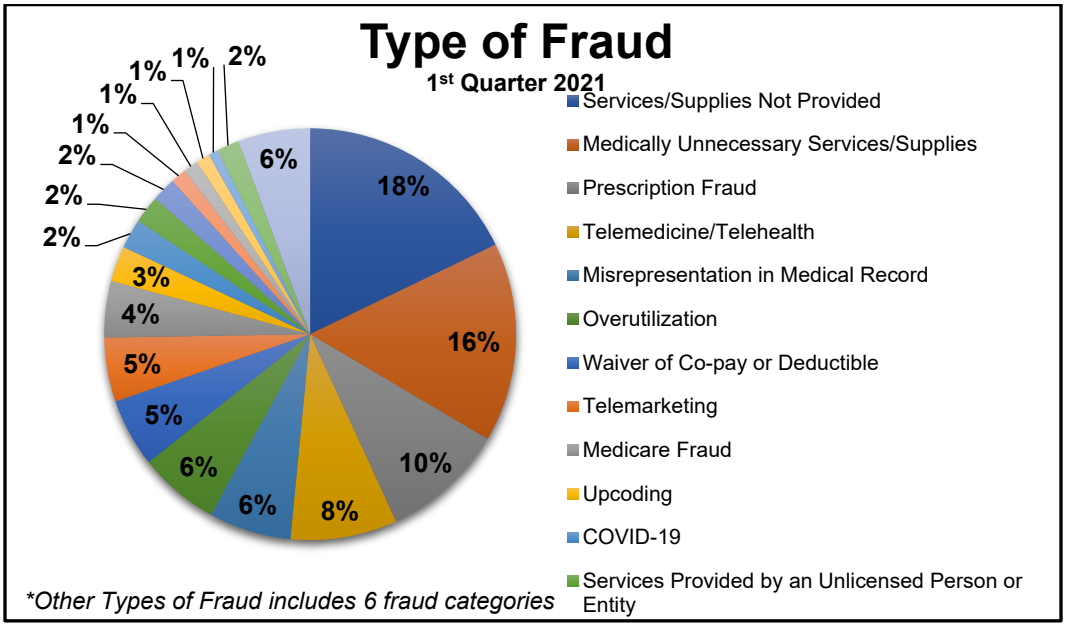
** Please note that the above reported Exclusion number represents the 2nd quarter for fiscal year 2021.*

SIRIS® QUARTERLY STATISTICS

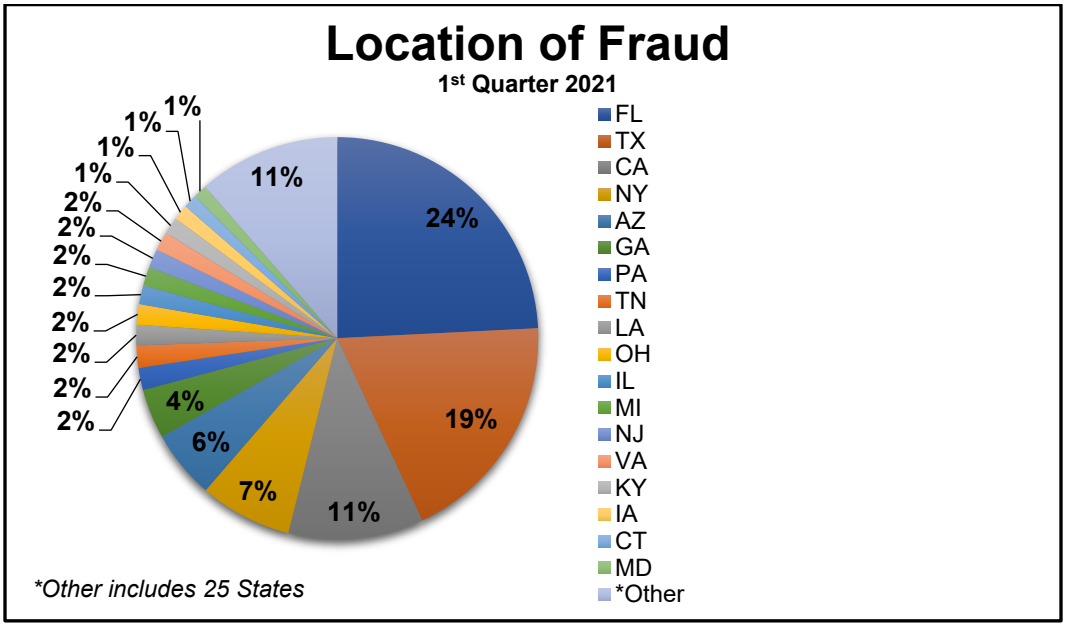
The following pie charts represent the compilation of the statistical reporting over the last 3 months (January – March 2021) of provider cases entered in SIRIS.



Observation: When compared to the previous quarter, the top four Types of Provider remained the same, however, Medical Doctor went from the third position to the top position.



Observation: When compared to the previous quarter, Services/Supplies Not Rendered returned to the topmost reported type of fraud. Medically Unnecessary Services/Supplies and Prescription Fraud remained in the top 2 and 3 positions, and Telemedicine/Telehealth moved to the 4th top position from the seventh most reported type of fraud.



Observation: As usual, Florida, Texas, California, and New York remained static in the top four Locations of Fraud reported.

Note: The location of fraud represents the state in which the provider's office is located. While most fraud occurs in the provider's office, please keep in mind that the actual fraud may have occurred in many locations/states.

Highmark

- Highmark Makes a $220M Impact in the Fight Against Healthcare Fraud, Waste and Abuse in 2020

Illinois Department of Healthcare and Family Services

- Office of Inspector General Annual Report – Fiscal Year 2020

Kaiser Permanente – Ethisphere World's Most Ethical Companies 2019-2021

For the third consecutive year, **Kaiser Permanente has been named one of the World's Most Ethical Companies by the Ethisphere Institute**.

Kaiser Permanente was 1 of 135 honorees worldwide, and 1 of only 2 organizations recognized in the Integrated Healthcare System category in 2021. The award honors organizations whose practices improve communities, build capable and empowered workforces, and foster corporate cultures focused on ethics and a strong sense of purpose.

For more information, please see the press release linked here, including a statement from Vanessa Benavides, Kaiser Permanente senior vice president and chief compliance and privacy officer.

Nebraska Department of Insurance, Fraud Prevention Division Newsletters

- January 2021

PA – Insurance Fraud Section Newsletters

- March 2021
- February 2021
- January 2021

Pennsylvania Insurance Fraud Prevention Authority Fraud Stories Newsletters

- January 2021
- 2020 Annual Report

Department of Justice Press Releases

- Court Enters $4.5 Million Judgment Against Owner of Defunct Urine Drug Testing Laboratory Resolving Allegations of Participation in Kickback Schemes (March 30, 2021)
- Pennsylvania Man Admits Role in $4.6 Million Kickback Scheme Related to Genetic Testing (March 26, 2021)
- Owner of Central Medical Systems Sentenced To 15 Months for Medicare Billing Fraud (March 26, 2021)
- Owner of Defunct Urine Drug Testing Laboratory Agrees to Pay Over $2 Million To Resolve Allegations of Participation in Kickback Scheme (March 26, 2021)
- Justice Department Takes Action Against COVID-19 Fraud (March 26, 2021)
- Novus Hospice CEO Pleads Guilty to Healthcare Fraud (March 19, 2021)
- uBiome Co-Founders Charged with Federal Securities, Health Care Fraud Conspiracies (March 18, 2021)
- Cardiologist Dinesh Shah Pays $2 Million To Resolve False Claims Act Allegations Relating to Excessive Testing (March 18, 2021)
- Physician pays nearly half million dollars to resolve home health care fraud allegations (March 18, 2021)
- Pharmacist Charged in $4 Million Health Care Fraud and Kickback Scheme (March 17,2021)
- Owner of Pharmacies in Brooklyn and Queens Charged in Healthcare Fraud and Kickback Scheme (March 17, 2021)
- Owner of Mental Health Services Agency Pleads Guilty to Health Care Fraud Charge (March 11, 2021)
- Pharmacy owner and accountant indicted in $134M health care fraud scheme (March 9, 2021)
- New Jersey Physician and Medical Practice Agree to Pay $106,255 to Resolve False Claims Act Allegations (March 8, 2021)
- Manhattan U.S. Attorney Announces Resolution of Civil and Criminal Healthcare Fraud Charges Against Vascular Surgeon for Fraudulently Billing Medicare For Medically Unnecessary Procedures (March 8, 2021)
- Former Police Officer Admits Role in Multimillion-Dollar Compounded Prescription Drug Scheme (March 8, 2021)
- Doctor Admits Role in Genetic Testing Kickback and Bribery Schemes (March 5, 2021)
- Owner and Employees of Alleged Pill Mill Facing Federal Indictment for an Oxycodone Distribution Conspiracy (March 5, 2021)
- Ohio Treatment Facilities and Corporate Parent Agree to Pay $10.25 Million to Resolve False Claims Act Allegations of Kickbacks to Patients and Unnecessary Admissions (March 5, 2021)
- Pharmacist Sentenced to More Than 14 Years in Federal Prison for a Drug Distribution Conspiracy and for Murder for Hire (March 4, 2021)
- South Bay Doctor Settles Federal Lawsuit Alleging He Accepted Illegal Kickbacks for Patient Referrals to Gardena Hospital (March 3, 2021)
- CEO Sentenced to Prison in $150 Million Health Care Fraud, Opioid Distribution, and Money Laundering Scheme (March 3, 2021)
- Allergy and Asthma Associates in Roanoke Pleads Guilty to Criminal Charge; Enters into Civil Resolution Over Health Care Fraud Allegations (March 2, 2021)
- Licensed Pharmacist Pleads Guilty to Making False Statements to The DEA About Controlled Substances (March 2, 2021)
- North Philadelphia “Pill Mill” Doctor Sentenced to Five Years in Prison for Illegal Opioid Distribution (March 2, 2021)
- Owner of Tennessee Drug Screening Lab Sentenced to 36 months on Federal Health Care Fraud Charge (March 2, 2021)
- North Carolina Durable Medical Equipment Corporation Sentenced for $10 Million Healthcare Fraud Scheme, and the Company and Its Owner Agree to Pay Millions to Resolve Related Civil Claims (March 2, 2021)

- Doctor Sentenced to Prison for Role in Unlawful Distribution of Controlled Substances (March 2, 2021)
- Maryland U.S. Attorney's Office Seizes Fourth Domain Name Purporting to be the Website of a Company Producing a Treatment for COVID-19 (March 1, 2021)
- Doctor Sentenced to Prison for Role in Unlawful Distribution of Controlled Substances (March 1, 2021)
- West Virginia hospital to pay more than $300,000 for Medicare fraud, (February 24, 2021)
- Two Women Plead Guilty in Multi-Million Dollar Medicare Fraud Scheme, (February 24, 2021)
- Justice Department files lawsuit against Creve Coeur pharmacist for Controlled Substances Act violations (February 24, 2021)
- Hospice Administrator Sentenced for Role in Hospice Fraud Scheme (February 19, 2021)
- Durable medical equipment company owner sentenced to federal prison for bribery conspiracy (February 12, 2021)
- Woman First in the Nation Charged with Misappropriating Monies Designed for COVID Medical Provider Relief (February 11, 2021)
- Man Sentenced for Health Care Fraud in Excess of $175,000, (February 9, 2021)
- Doctor Sentenced for Role in Unlawful Distribution of Opioids (February 8, 2021)
- Judge sentences 'Doctors on the Go' owner to nine years in prison for fraud and receiving kickbacks (February 5, 2021)
- Compounding Pharmacy and Owner Plead Guilty to Health Care Fraud and Kickback Scheme that Led to $14 Million in Payments (February 5, 2021)
- Healthcare Company and Lab Pay $845K to Resolve Federal and State False Claims Act Allegations (February 5, 2021)
- Local Businesswoman Pleads Guilty to Criminal Healthcare and Tax Fraud Charges and Agrees To $20.3 Million Civil Settlement (February 4, 2021)
- Owner of Georgia Consulting Company and Texas Man Charged in $2.7 Million Genetic Testing Kickback Scheme (February 4,2021)
- Maine Man Pleads Guilty to Drug Trafficking, Firearm, and Fraud Offenses (January 29, 2021)
- Burlington County Doctor Sentenced to 33 Months in Prison for Role in $24 Million Telemedicine Compounded Medication Scheme (January 27, 2021)
- Five New Guilty Pleas in Nationwide Telemedicine Pharmacy Health Care Fraud Conspiracy (January 25, 2021)
- Estate of Deceased Urologist Agrees to Pay More Than $1.7 Million to Settle False Claims Act Liability (January 22, 2021)
- Maryland Woman Sentenced for Committing Health Care Fraud: Government Continues Crackdown on People Who Defraud Medicaid (January 22, 2021)
- AG Grewal Announces Multi-Million Dollar Settlement with Insys Therapeutics Founder John Kapoor over His Role in Fueling the Opioid Epidemic (January 21, 2021)
- Hospice, home health agency and owners pay over $1.8M to resolve claims concerning physician payments (January 19, 2021)
- Two Defendants Plead Guilty to Multi-Million Dollar Medicare Fraud Scheme (January 20, 2021)
- Federal Court Restrains Toledo Pharmacy and Two Pharmacists from Dispensing Opioids or Other Controlled Substances (January 15, 2021)
- Pharmacy Owner's Son Admits Role in $24.8 Million Kickback Scheme and $9 Million Conspiracy to Defraud IRS (January 14, 2021)
- Texas Company Agrees to Reimburse Medicare for Improper Billing Related to Neurostimulators (January 12, 2021)
- Patient Recruiter Convicted in $2.8 Million Telemedicine Scheme Against Medicare (January 11, 2021)
- AutoGenomics, Inc. Agrees to Pay Over $2.5 Million for Allegedly Paying Kickbacks (January 11, 2021)
- Ex-Indian Health Services doctor sentenced to prison, fined for drug kickback scheme while at Blackfeet Indian Reservation (January 7, 2021)

- Anchorage Doctor Sentenced for Prescribing Medically Unnecessary Opioids in Health Care Fraud Scheme (January 6, 2021)
- California Genetic Testing Lab Agrees to Pay $357,584 to Resolve False Claims Act Allegations (January 6, 2021)
- The United States and Tennessee Resolve Claims with Three Providers for False Claims Act Liability Relating to "P-Stim" Devices for A Total Of $1.72 Million (January 4, 2021)

HHS-OIG

- List of Excluded Individuals and Entities
- CMS Use of Data on Nursing Home Staffing: Progress and Opportunities to Do More (March 9, 2021)
- OIG Warns Telehealth Industry: "With Great Power Comes Great Responsibility", (March 10, 2021)
- Peninsula Regional Medical Center: Audit of Medicare Payments for Polysomnography Services (March 4, 2021)
- Medicare Home Health Agency Provider Compliance Audit: Brookdale Home Health, LLC (February 25, 2021)
- Five New Guilty Pleas in Nationwide Telemedicine Pharmacy Health Care Fraud Conspiracy (January 25, 2021)
- Choctaw Nation of Oklahoma Made Progress Toward Meeting Program Goals During the First Year of Its Tribal Opioid Response Grant (January 20, 2021)
- Independent Attestation Review: Substance Abuse and Mental Health Services Administration Fiscal Year 2020 Detailed Accounting Report, Performance Summary Report for National Drug Control Activities, Budget Formulation Compliance Report, and Accompanying Required Assertions (January 15, 2021)
- State Enforcement Actions

State News/Press Releases

- Florida
  - Dental Hygienist Practicing as Unlicensed Dentist Arrested for Medicaid Fraud (March 5, 2021)
  - Behavior Health Analyst Arrested for Medicaid Fraud (March 4, 2021)
  - FL Attorney General Moody Announces Multimillion-Dollar Recovery Following Investigation into Assisted Breathing Device Rentals (January 20, 2021)
- Massachusetts
  - AG Healey Issues Updated Advisory to Warn Residents About COVID-19 Vaccine Scams (March 30, 2021)
  - AG Healey Secures $1.25 Million From Lawrence Home Health Care Company That Falsely Billed MassHealth (March 22, 2021)
  - AG Healey Sues Orthodontist for Keeping Children in Braces Longer Than Medically Necessary (March 1, 2021)
- North Carolina
  - Attorney General Josh Stein Announces Health Care Fraud Sentencing (February 26, 2021)
- Nevada
  - Attorney General Ford Announces Felony Convictions of Medicaid Healthcare Providers (March 17, 2021)
- Washington
  - AG Ferguson: Mesh Manufacturer Boston Scientific Will Pay More than $8.8 Million for Failing to Disclose Risks of its Transvaginal Mesh Devices (March 23, 2021)

Articles of Interest

- False Claims Act Enforcement in 2021: A Look Ahead, JD Supra, March 31, 2021
- While COVID-19 Takes Center Stage, DOJ Continues to Target Providers for Opioid Epidemic, JD Supra, March 30, 2021
- The Medical Fraud Case that could Tear a Community Apart: Seeking Justice or Prosecutorial Grandstanding?, Prescott News, March 26, 2021
- Lorain County Public Health issues warning about fake COVID-19 remedy containing bleach being sold locally, News 5 Cleveland, March 15, 2021
- Shoreline clinic owner is guilty of health care fraud, Yahoo News, March 11, 2021
- United States: Individual Prosecutions Down but Corporate Resolutions Steady for DOJ's Fraud Section In 2020, With More in The Pipeline, Mondaq, March 10, 2021
- Telehealth Compliance: Don't Be Complacent During COVID-19, JD Supra, March 3, 2021
- FL woman pleads guilty to role in medical brace fraud following I-Team investigation, Yahoo! News, February 9, 2021
- FBI warns of fraud schemes related to COVID-19 vaccines, East Idaho News, February 2, 2021
- Toms River Pair Charged In $4.5M Health Care Fraud Scheme, The Patch, January 28, 2021

LexisNexis Fraud of The Day

- Knowledge vs. Wisdom
- Like Father, Like Son
- Cracking the Ethics Code
- Pyramid Scheme
- Trio of Trouble
- Pharmacy Conspiracy Scheme Goes Awry
- An Addiction to Fraud
- Take Off the White Coat
- Dental Hero Turns Sour
- An Abundance of Lies
- Exploiting Addictions

- **COVID Feature**
  - From Lovebirds to Jailbirds
  - Loaning Myself Some Money
  - Snowball Effect
  - Sometimes, It's Better to be Last
  - A Slice of Cheese
  - It Takes All of Us
  - Slice of the Pie
  - Home Sweet Home
  - It Takes All of Us
  - The Wages of Fraud is Prison
  - High Roller
  - Busy Year for Fraud
  - Double Scam
  - Caught, Charged, Convicted, and Sentenced
  - Unprecedented Fraud
  - The Wizards of Fraud
  - Another Day, Another Dollar

- **Medicaid Fraud**
  - The Birth of a Fraudulent Scheme
  - Double-Booked
  - Drugs, Weapons, and Fraud
  - Testing, Testing, 1-2-3
  - Superman or Super Liar?
  - Long Way from Home
  - The Perfect Pair
  - Slowly but Surely
  - Gross Negligence
  - Like Mother, Like Daughter
  - Gambled and Lost
  - Skimming
  - New Year, Same Shenanigans

- **Medicare Fraud**
  - Emotional Turmoil
  - A Wolf in Sheep's Clothing
  - Eligible for Prison
  - The Grim Reaper Cometh
  - Bevy of Fraudsters

- **Workers Comp and Disability Fraud**
  - Inadequate Coverage
  - From Soup to Workers Comp Fraud
  - Something's Shifty
  - True Abilities
  - Hit Head On

AGENCY DESCRIPTIONS

The FBI is the primary agency for exposing and investigating health care fraud, with jurisdiction over both federal and private insurance programs. We use our analytic expertise to identify key trends and tap into our investigative partnerships with federal, state, and local agencies, as well as our relationships with national groups and associations, to uncover fraud. Our field offices also proactively target fraud through coordinated initiatives, task forces and strike teams, and undercover operations. The FBI works closely with its federal, state, and local law enforcement partners; the Centers for Medicare and Medicaid Services; and other government and privately sponsored program participants to address vulnerabilities, fraud, and abuse.

The U.S. Department of Health and Human Services (HHS), Office of Inspector General's (OIG) mission is to protect the integrity of HHS programs as well as the health and welfare of program beneficiaries. Since its 1976 establishment, OIG has been at the forefront of the Nation's efforts to fight fraud, waste, and abuse in Medicare, Medicaid, and more than 100 other HHS programs. HHS-OIG is the largest inspector general's office in the Federal Government, with more than 1,700 employees dedicated to combating fraud, waste, and abuse and to improving the efficiency of HHS programs. Click here for more information regarding HHS-OIG.

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. State-of-the-art tools and technology assist OIG investigators around the country and help OI meet its goal of being the world's premier health care law enforcement agency. Click here for more information regarding the Office of Investigations.

The Office of Labor Racketeering and Fraud Investigations (OLRFI) is responsible for conducting criminal, civil, and administrative investigations relating to violations of Federal laws, rules or regulations pertaining to Department of Labor (DOL) programs, grants, contracts, and operations, as well as allegations of criminal activity and serious misconduct on the part of DOL employees. In relation to healthcare fraud, the OLRFI investigates fraudulent activity in Office of Workers Compensation Programs (OWCP). These investigations focus on fraud activity involving four major disability programs: Federal Employees' Compensation Act Program, Energy Employees Occupational Illness Compensation Program, Coal Mine Workers Compensation Program (Black Lung), and Longshore and Harbor Workers' Compensation Program.

The Office of Personnel Management Office of the Inspector General (OPM OIG) is responsible for preventing fraud, waste, and abuse within all OPM administered programs through audits and investigations. From a health care perspective, the OPM/OIG has primary oversight of the Federal Employees Health Benefits Program (FEHBP), a Federally funded health care program. The FEHBP, established by the Federal Employee Health Benefit Act (FEHB), Public Law 86-382, is the largest employer-based health care program in the United States.

The VA Office of Inspector General, Office of Investigations, conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for healthcare benefits (to include identity theft), and other fraud relating to the delivery of health care to millions of veterans and their dependents.

The Office of Medicaid Program Integrity (MPI) is located within the Office of the Inspector General and fulfills the Agency for Health Care Administration's (Agency) state and federal law obligations related to preventing, detecting, and auditing fraud, abuse, and waste, as well as initiating the recovery of overpayments in the Medicaid program, as defined in s.409.913, F.S. and 42 CFR 455. These broad categories of program integrity activities align with the organizational units of detection, prevention, recoupment, managed care, and administrative support within the Office of Medicaid Program Integrity (MPI). MPI is a unique component of the Agency's Office of Inspector General in that most Florida inspectors general offices do not house an administrative enforcement arm within their structure.

Back to Top