# Department of Justice

**STATEMENT**

**OF**

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**BEFORE THE**

**SENATE FINANCE COMMITTEE**

**ENTITLED**

**“ANATOMY OF A FRAUD BUST:**
**FROM INVESTIGATION TO CONVICTION”**

**PRESENTED ON**

**APRIL 24, 2012**

**Statement of**
**Wifredo A. Ferrer**
**United States Attorney**
**Southern District of Florida**

**Before the**
**Senate Finance Committee**
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## INTRODUCTION

Chairman Baucus, Ranking Member Hatch, and distinguished Members of the Committee. Thank you for inviting me to speak with you today about the Department of Justice's efforts to combat health care fraud. I am honored to appear before you on behalf of the Department of Justice (the Department), along with my colleagues, Peter Budetti from the Centers for Medicare and Medicaid Services (CMS), and Daniel Levinson from the Office of Inspector General, Department of Health and Human Services (HHS-OIG). The Department is grateful to the Committee for its leadership in this area, and we appreciate the opportunity to appear before you here today.

Health care fraud is a serious and costly law enforcement problem facing our country. It threatens the integrity of Medicare, as well as all Federal, State, and private health care programs. Every year the Federal Government spends hundreds of billions of dollars to provide health care to the most vulnerable of our society - our seniors, children, disabled, and needy. We have a duty to ensure that these funds are spent on providing proper medical treatment to our citizens, and while most medical providers and health care companies are doing the right thing, there are some health care providers, as well as criminals, that target Medicare and other

government and private health care programs for their own financial benefit. Every dollar stolen from our health care programs is one dollar too many. Medicare and Medicaid fraud can also corrupt the medical decisions health care providers make with respect to their patients, placing patients at risk of harm from unnecessary or unapproved treatments. For these reasons, fighting health care fraud is a priority of the Department of Justice. As you know, the 93 United States Attorneys and their assistants, or AUSAs, are the principal prosecutors of Federal crimes, including health care fraud, representing the Department of Justice and the interests of the American taxpayer. Together with attorneys from the Civil, Criminal and Civil Rights Divisions (the Civil Rights Division enforces the Civil Rights of Institutionalized Persons Act) we appear in both criminal and civil cases in the Federal courts in the 94 judicial districts across the country. And with agents from the FBI, our colleagues at HHS-OIG and CMS, and other affected Federal agencies, we are fighting back. We investigate, prosecute, and secure prison sentences for hundreds of defendants every year, and we are recovering billions of dollars in stolen funds. With the additional resources provided to us by Congress over the past 3 years, we are making significant strides in this battle.

**FIGHTING MEDICARE AND MEDICAID FRAUD IS A PRIORITY OF THE DEPARTMENT OF JUSTICE**

Because coordination across Departments is an integral part of preventing and prosecuting health care fraud, Attorney General Holder and Secretary Sebelius together have pledged to strengthen our fight against waste, fraud and abuse in Medicare and Medicaid. As you know, to improve that coordination, in May 2009, they announced the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT), a senior level, joint task force, designed to marshal the combined resources of both agencies in new ways to combat all facets of the health care fraud problem. With the creation of HEAT, we are committed to making fighting

health care fraud a Cabinet-level priority for both DOJ and HHS. By joining forces to coordinate Federal, State, and local law enforcement activities to fight health care fraud, our efforts have seen unprecedented success. In FY 2011 alone, the government's health care fraud and prevention efforts recovered nearly $4.1 billion related to health care fraud and false claims and returned these funds to CMS, the U.S. Treasury, other Federal agencies, and individuals. This is the highest annual amount ever recovered from doctors and companies who attempted to defraud seniors and taxpayers or who sought payments to which they were not entitled.

**THE DEPARTMENT'S CIVIL HEALTH CARE FRAUD WORK**

The Department's civil attorneys – both in the United States Attorneys' Offices and the Department's Civil Division – aggressively pursue civil enforcement actions to root out fraud and recover funds stolen in health care fraud schemes, often through the use of the False Claims Act (FCA), 31 U.S.C. §§ 3729-3733, one of the Department's most powerful civil enforcement tools. This success under the FCA is perhaps best illustrated by the results: Nearly every year since 2000, our attorneys, working with the Federal Bureau of Investigation (FBI), HHS-OIG, and other Federal, State, and local law enforcement agencies, have obtained total settlements and judgments under the FCA that exceeded $1 billion. In FY 2011, the Department secured approximately $2.4 billion in civil health care fraud settlements and judgments--amounts that contributed to $4.1 billion recovered that year. This marked the second year in a row that more than $2 billion has been recovered in FCA health care matters. Since the HEAT initiative began, the USAOs and the Department's Civil Division have obtained more than $8.8 billion in settlements, judgments, fines, restitution and forfeiture in health care matters pursued under the FCA and the Food Drug and Cosmetic Act.

In one such matter in which my office played a key role, Abbott Laboratories Inc., and three other pharmaceutical manufacturers paid more than $700 million to settle False Claims Act allegations that they engaged in a scheme to report false and inflated prices for numerous pharmaceutical products knowing that Federal healthcare programs relied on those reported prices to set payment rates. The actual sales prices for the products were far less than what defendants reported. The difference between the resulting inflated government payments and the actual price paid by healthcare providers for a drug is referred to as the "spread." The larger the spread on a drug, the larger the profit for the health care provider or pharmacist who gets reimbursed by the government. The government alleged that these manufacturers created artificially inflated spreads to market, promote and sell the drugs to existing and potential customers. Because payment from the Medicare and Medicaid programs was based on the false inflated prices, we alleged that the defendants caused false claims to be submitted to Federal healthcare programs, and as a result, the government paid millions of claims for far greater amounts than it would have if the manufacturers had reported truthful prices.

**THE DEPARTMENT'S CRIMINAL HEALTH CARE FRAUD WORK**

The Department's criminal health care fraud efforts have also been a tremendous success. Since 2009, the Department and HHS have enhanced their coordination through HEAT, steadily increasing the number of Medicare Fraud Strike Force (MFSF) teams, a supplement to the Department's criminal health care fraud enforcement efforts. Strike Force teams are collaborative efforts that combine prosecutors from the USAOs, prosecutors from the Criminal Division's Fraud Section, who are devoted exclusively to the prosecution of health care fraud cases, and Federal agents from the FBI, and HHS-OIG. In some cases, local law enforcement agents also participate. In FY 2011, the total number of cities with strike force prosecution

teams was increased to nine. The Criminal Division and each USAO in the strike force cities together allocate several prosecutors and support personnel to this important initiative. The MFSFs use advanced data analysis techniques to identify high, or unusual billing patterns in health care fraud hot spots so that interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers. This model is working. The strike forces have been an unqualified success.

Today, our criminal enforcement efforts are at an all-time high. In FY 2011, strike force operations charged a record number of 327 defendants, who allegedly collectively billed the Medicare program more than $1 billion. Strike force teams secured 201 criminal convictions, and sentenced 175 defendants to prison. The average prison sentence in strike force cases in FY 2011 was more than 47 months. Including strike force matters, Federal prosecutors filed criminal charges against a total of 1,430 defendants for health care fraud related crimes. This is the highest number of health care fraud defendants charged in a single year in the Department's history. Including strike force matters, a total of 743 defendants were convicted for health care fraud-related crimes during the year.

Typical strike force cases include schemes to submit claims to Medicare for treatments that were medically unnecessary or never provided; or allegations that patient recruiters, Medicare beneficiaries, and other co-conspirators were paid cash kickbacks in return for supplying beneficiary information to providers so that those providers could submit false Medicare claims using the names of beneficiaries.

## RECENT MFSF OPERATIONS

### 91 Individuals Charged for Approximately $295 Million in False Billing

In September, 2011, Attorney General Holder and Secretary Sebelius announced a nationwide takedown by MFSF operations in eight cities that resulted in charges against 91 defendants, including doctors, nurses, and other medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $295 million in false billing. This coordinated takedown involved the highest amount of false Medicare billings in a single takedown in Strike Force history.

As previously detailed, the MFSFs consist of multi-agency teams of Federal, State, and local investigators designed to combat Medicare fraud through the use of Medicare data analysis techniques and an increased focus on community policing. For this Strike Force operation, approximately 400 law enforcement agents from the FBI, HHS-OIG, multiple Medicaid Fraud Control Units, and other State and local law enforcement agencies participated in the takedown. In addition to making arrests, agents also executed 18 search warrants in connection with ongoing strike force investigations.

The defendants charged are accused of various health care fraud-related crimes, including conspiracy to defraud the Medicare program, health care fraud, violations of the anti-kickback statutes and money laundering. The charges are based on a variety of alleged fraud schemes involving various medical treatments and services such as home health care, physical and occupational therapy, mental health services, psychotherapy and durable medical equipment (DME).

The defendants allegedly participated in schemes to submit claims to Medicare for treatments that were medically unnecessary and oftentimes never provided. In many cases, indictments and complaints allege that patient recruiters, Medicare beneficiaries and other co-conspirators were paid cash kickbacks in return for supplying beneficiary information to providers, so that the providers could submit fraudulent billing to Medicare for services that were medically unnecessary or never provided. The following is a breakdown of the MFSF takedown by district:

In Miami, 46 defendants, including one doctor and one nurse, were charged for their participation in various fraud schemes involving a total of $159 million in false billings for home health care, mental health services, occupational and physical therapy, DME and HIV infusion. In one case, 24 defendants were charged for participating in a community mental health center fraud scheme involving more than $50 million in fraudulent billing. The defendants allegedly paid patient recruiters to refer ineligible beneficiaries to the mental health center. In some instances, beneficiaries who were residents of halfway houses were allegedly threatened with eviction if they did not agree to attend the mental health center.

In Houston, two individuals were charged with fraud schemes involving $62 million in false billings for home health care and DME. One defendant allegedly sold beneficiary information to 100 different Houston-area home health care agencies in exchange for illegal payments. The indictment alleges that the home agencies then used the beneficiary information to bill Medicare for services that were unnecessary or never provided.

Ten defendants were charged in Baton Rouge, La., for participating in schemes involving more than $24 million related to false claims for home health care and DME. According to one

indictment, a doctor, nurse and five other co-conspirators participated in a scheme to bill Medicare for more than $19 million in skilled nursing and other home health services that were medically unnecessary or never provided.

Six defendants, including two doctors, were charged in Los Angeles for their roles in schemes to defraud Medicare of more than $10.7 million. In Brooklyn, three defendants, including two doctors, were charged for a fraud scheme involving more than $3.4 million in false claims for medically unnecessary physical therapy. And in Detroit, 18 defendants, including three doctors, were charged for schemes to defraud Medicare of more than $28 million. According to an indictment, 14 of the defendants participated in a home health care scheme that submitted more than $14 million in false claims to Medicare. Finally, four defendants including one doctor were charged in Chicago for their alleged roles in schemes to defraud Medicare of more than $4.4 million.

**U.S. ATTORNEY'S OFFICE FOR THE SOUTHERN DISTRICT OF FLORIDA**

The AUSAs in my own district, the Southern District of Florida, have handled a wide variety of health care matters, including false billings by doctors and other providers of medical services, overcharges by hospitals, Medicaid fraud, kickbacks to induce referrals of Medicare and Medicaid patients, fraud by pharmaceutical and medical device companies, and failure of care allegations against nursing home owners. The following is a recent example of a case brought by the Miami Strike Force, which demonstrates the health care fraud efforts in my district:

**ABC HOME HEALTH CARE INC. AND FLORIDA HOME HEALTH CARE PROVIDERS, INC.**

**The Home Health Care Scheme**

Beginning in approximately 2006 and lasting until early 2011, there was a pervasive health care fraud scheme in South Florida in which home health care agencies billed Medicare for home health care services that were either not provided or were not medically necessary. Medicare pays home health care agencies to provide services such as skilled nursing and physical and occupational therapy to patients who are homebound, i.e., patients who cannot leave their home to go to the office of a health care provider. In a typical case, a patient may have just been released from the hospital following surgery, and may need a therapist or nurse to come to their home for a period of time until they are well enough to leave the home. In the typical case, the hospital or physician would refer a patient to a list of home health care agencies, from which the patient would select one, which in turn would provide the necessary home health care.

From 2006 to 2011, fraudulent home health care agencies operating in the Miami area, rather than obtaining legitimate referrals from physicians or hospitals for patients who needed home health care, employed, or contracted with, patient recruiters, who were paid kickbacks and bribes to obtain patients who had Medicare benefits. The home health agencies primarily billed Medicare on behalf of these patients for two types of home health services -- physical and occupational therapy, and skilled nursing for diabetic patients who supposedly required insulin injections. The home health care agencies paid larger kickbacks to recruiters for patients who were diabetic, since they could then bill Medicare for a skilled nurse to provide the patient with insulin injections three times a day, seven days a week. In reality, many patients can control their diabetes with oral medications, and do not require injections. Even among those that

require injections, more than 90% of diabetic patients can self-inject, and do not require a skilled nurse to treat their diabetes. But fraudulent providers would obtain prescriptions from doctors for home health for any patient who was diabetic, and Medicare would be billed for hundreds of home visits for nurses who would purportedly inject the patient with insulin.

**ABC Home Health, Inc.**

ABC Home Health, Inc. (ABC) was a Miami home health care agency that operated under the direction and ownership of Gladys Zambrana (Zambrana), Enrique Perez and Alex Hernandez from approximately January 2006 through December 2008. A review of Medicare billing data showed that almost every Medicare beneficiary who received home health care services from ABC during this period purportedly received the exact same treatment: daily insulin injections by nurses and home health care aides and/or physical therapy. According to Medicare data, ABC submitted false claims to the Medicare program for approximately $17 million in home health services that ABC purportedly rendered to approximately 391 beneficiaries. As a result of the submission of these claims, Medicare made payments to ABC totaling approximately $11.2 million.

**Florida Home Health Care Providers, Inc.**

Florida Home Health Care Providers, Inc. (Florida Home Health) was a Miami home health care agency that was also operated by Zambrana, assisted by Carlos Castaneda, from approximately October 2007 through March 2009. A review of Medicare billing data showed that each Medicare beneficiary who received home health care services from Florida Home Health during this period of operation purportedly received the exact same treatment: daily insulin injections by nurses and home health care aides and/or physical therapy. According to Medicare data, from approximately October 2007 through March 2009, Florida Home Health

submitted to the Medicare program false claims for approximately $7.8 million in home health services that Florida Home Health purportedly rendered to approximately 223 beneficiaries. As a result of the submission of these claims, Medicare made payments to Florida Home Health totaling approximately $5.4 million.

Ultimately, the total amount in fraudulent billing to the Medicare program by ABC and Florida Home Health was approximately $25 million.

**ABC and Florida Home Health Scheme**

ABC and Florida Home Health existed for the purpose of billing the Medicare program for expensive home health services that were not medically necessary and not provided. Zambrana's scheme was for her and co-conspirators to pay doctors kickbacks and bribes in order to qualify patients for home health care, refer them to ABC and Florida Home Health, and sign Plan of Care (POC) forms for ABC and Florida Home Health to use as justification for the billings to Medicare. The POCs for the patients were created at the ABC and Florida Home Health offices and then given to the physicians to sign, which they did in exchange for kickbacks and bribes.

As part of the scheme, ABC and Florida Home Health employed patient recruiters to recruit and place patients with ABC and Florida Home Health. The owners paid kickback payments to the recruiters in various forms – cash and check. At ABC and Florida Home Health, patient recruiters were paid between $800 and $1000 per patient per month for patients that could be billed for physical therapy. Further, at ABC and Florida Home Health, patient recruiters were paid between $1200 and $1500 per patient per month for patients that could be billed for skilled nursing care for diabetes injections. ABC and Florida Home Health maintained a ledger that listed many of the patient recruiters and the beneficiaries recruited by that recruiter.

In most instances, the Medicare beneficiaries were in on the scheme. For example, if ABC and Florida Home Health paid a recruiter $1500 per month for a patient that could be billed for diabetic injections two and three times a day, that recruiter would often pay that patient up to $1200 of that $1500 in a kickback.

At ABC and Florida Home Health, patient recruiters and patients were paid huge sums of money because for each patient prescribed home health care for diabetic injections and referred to ABC and Florida Home Health, ABC and Florida Home Health billed Medicare approximately $10,000 - $14,000 in fraudulent billings every 60 days. Many of the patients at ABC and Florida Home Health were prescribed home health services month after month. ABC and Florida Home Health primarily billed Medicare for home health skilled nursing visits two and three times a day for patients that purportedly needed insulin injections two and three times a day. These types of patients were billed by ABC and Florida Home Health because Medicare would reimburse the most money for these types of patients. In reality, the patients did not need the injections, but rather treated their diabetes with oral medications. If the patients did, in fact, need insulin injections, the patients generally could have self-injected.

As part of the scheme, ABC and Florida Home Health hired nurses. Through ABC and Florida Home Health, the nurses would purportedly provide home care services, including insulin injections to beneficiaries that had been prescribed home health by the co-conspirator doctors. ABC and Florida Home Health paid these nurses $25 per visit, but knew that the nurses often did not visit the patients. In most instances, the nurses did not actually provide the nursing visits two and three times a day as prescribed because the patients did not qualify and did not need the diabetic injection services.

At ABC and Florida Home Health, the nurses falsified their nursing notes to make it appear that the patients qualified for the services. Specifically, the nurses manipulated the nursing notes to show not-existent symptoms. This process would ensure that patients appeared to qualify for home health care and that ABC and Florida Home Health could bill Medicare for home health services. These symptoms included hand tremors, unsteady gait and shortness of breath – all symptoms that would make it appear that the patients could not leave their homes and could not inject themselves.

**The Strike Force Combats the Scheme**

The task of dismantling this complex scheme fell to one of the Strike Force teams of the Miami Strike Force, which is a joint effort between the Criminal Division's Fraud Section, the USAO for the Southern District of Florida, the FBI, and HHS-OIG. The particular team tasked with taking down the ABC scheme included one prosecutor from the Criminal Division's Fraud Section, three agents from the FBI and three agents from HHS-OIG.

The investigation into ABC and Florida Home Health began in Winter of 2008. Sophisticated data analysis revealed that ABC and Florida Home Health billed for medical services for massive amounts of Medicare beneficiaries that would only be necessary for a small portion of the Medicare beneficiary population – a clear aberration. Analysis of ABC and Florida Home Health bank records showed large sums of money transferred to sham companies and subsequently turned into cash. Agents conducted search warrants simultaneous with initial arrests to seize patient files, which had been doctored.

Approximately six months after the investigation began, in June 2009, the two owners of ABC and Florida Home Health, together with six other defendants were indicted. The eight defendants in that case pled guilty. Many of the initial defendants cooperated, allowing the team

to charge fifteen additional defendants in December 2009, including Dr. Fred Dweck, a physician who signed prescriptions and POCsfor ABC and Florida Home Health, eleven nurses who purportedly provided home health services for which the two agencies billed the Medicare program, two patient recruiters, and one beneficiary. Fourteen of the fifteen defendants pled guilty. One defendant, Antonio Ochoa, a patient recruiter, was convicted of conspiracy to commit health care fraud and substantive kickbacks counts after a trial in September 2010.

In July 2010, ten additional defendants were indicted who were connected to the scheme, including one doctor, eight nurses who purportedly provided home health services for which the two agencies billed the Medicare program, and one beneficiary. Of the ten defendants, eight nurses and one beneficiary pled guilty to conspiracy to commit health care fraud.

In February 2011, twenty-one additional defendants were indicted, including Dr. Jose Nunez (Nunez), a physician who signed prescriptions and POCs for patients of ABC and Florida Home Health. In addition to Nunez, the February 2011 indictment included: one doctor, six nurses, eleven patient recruiters and two office administrators. Of the twenty-one defendants included in the Nunez Indictment, nineteen pleaded guilty to conspiracy to commit health care fraud, including Dr. Jose Nunez.

In sum, beginning with the initial indictment in June 2009 and continuing through February 2011, in less than 18 months, the Medicare Fraud Strike Force's investigation of ABC and Florida Home Health resulted in four separate indictments totaling 54 defendants. 51 of those defendants were convicted of felony offenses. The unprecedented success of the ABC/Florida Home Health case, which involved a complex fraud involving multiple physicians, dozens of nurses and hundreds of patients, was the result of just one Strike Force team. The

team work and success of this team demonstrates that the model, in fact, not only works, but exceeds traditional models of prosecution.

**The Results of the Strike Force Model**

As noted above, the Strike Team that led the ABC/Florida Home Health investigation demonstrated that health care fraud, even especially complex health care fraud, can be targeted quickly and successfully. This team successfully facilitated the identification and charging of defendants at all levels of the scheme; owners, nurses, patient recruiters, doctors and Medicare beneficiaries.

To date, Miami Medicare Fraud Strike Force's home health care fraud initiative, which started in June 2009 with the ABC case, has led to 63 defendants being charged, and resulted in 60 convictions. The defendants charged to date collectively billed Medicare and Medicaid more than $127 million.

**CONCLUSION**

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) established a national Health Care Fraud and Abuse Control Program (HCFAC) under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (HHS). The program was designed to coordinate Federal, State, and local law enforcement activities with respect to health care fraud and abuse. In its sixteenth year of operation, , strengthened by the new tools and resources provided by the Affordable Care Act, and reaffirmed by the commitment of the HEAT initiative to improve that coordination, the program's continued success again confirms the soundness of a collaborative approach to identify and prosecute the most egregious instances of health care fraud, to prevent future fraud or abuse, and to protect program beneficiaries.

AUSAs in the U.S. Attorneys' Offices, trial attorneys in the Civil, Civil Rights, and Criminal Divisions, FBI and HHS agents, as well as other Federal, State, and local law enforcement partners are working together across the country with unprecedented success. Since the HCFAC Program was established, working together, the two Departments have returned over $20.6 billion to the Medicare Trust Funds. We are poised to continue these successes in the years ahead, and look forward to continuing this important work with our Federal, State, and local partners to that end.

Thank you for the opportunity to provide this overview of the Department's health care fraud efforts and successes. I would be happy to respond to any questions you might have.