

Medicare Fraud “Strike Force Teams” Turn Up The HEAT

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Federal agents have been serving warrants, conducting raids, and making arrests across Houston, Texas, as part of a widespread effort to aggressively pursue Medicare and Medicaid fraud activities.¹ Similar efforts have been taking place in Detroit, Miami, and Los Angeles with success in recent weeks.² The fraud strike force operations are part of the newly-created Health Care Fraud Prevention & Enforcement Action Team (HEAT), a joint effort between the Department of Justice (DOJ) and the Department of Health and Human Services (HHS) to prevent fraud and vigorously enforce current anti-fraud laws nationwide.³

Background

In 2008, federal government agencies secured nearly 600 criminal convictions and a billion dollars in health care fraud monies under the federal False Claims Act.⁴ This year even more time and effort has been spent fighting healthcare fraud through the joint creation of the HEAT team by Attorney General Eric Holder and Kathleen Sebelius, Secretary of HHS. In short, the mission of HEAT is:

- to collectively use resources across government to prevent waste, fraud, and abuse in the Medicare and Medicaid programs;
- to reduce health care costs and improve the quality of care by securing convictions of those defrauding the government; and

¹ James Pinkerton and Mary Flood, *Agents Conduct Medical Fraud Raids Across Houston*, HOUS. CHRON., July 29, 2009, <http://www.chron.com/dispatch/story.mpl/metropolitan/6552547.html>.

² See e.g. U.S. Dep't of Health & Human Servs., Press Release, *Los Angeles Jury Convicts Equipment Suppliers of Medicare Fraud*, July 17, 2009, <http://www.hhs.gov/news/press/2009pres/07/20090717e.html>; Cindy Horswell, *Feds Strike at Medicare Fraud Here*, HOUS. CHRON., July 12, 2009, http://www.chron.com/CDA/archives/archive.mpl?id=2009_4764686; U.S. Dep't of Health & Human Servs., Press Release, *Eight Miami-Area Residents Charged in \$22 Million Medicare Fraud Scheme Involving Home Health Care Agencies*, June 26, 2009, <http://www.hhs.gov/news/press/2009pres/06/20090626a.html>; U.S. Dep't of Health & Human Servs., Press Release, *Eight Miami-Area Residents Charged in \$22 Million Medicare Fraud Scheme Involving Home Health Care Agencies*, June 26, 2009, <http://www.hhs.gov/news/press/2009pres/06/20090626a.html>; U.S. Dep't of Health & Human Servs., Press Release, *Medicare Fraud Strike Force Operations Lead to Charges Against 53 Doctors, Health Care Executives and Beneficiaries for More Than \$50 Million in Alleged False Billing in Detroit*, June 24, 2009, <http://www.hhs.gov/news/press/2009pres/06/20090624a.html>.

³ U.S. Dep't of Health & Human Servs., Press Release, *Medicare Fraud Strike Force Operations Lead to Charges Against 53 Doctors, Health Care Executives and Beneficiaries for More Than \$50 Million in Alleged False Billing in Detroit*, June 24, 2009, <http://www.hhs.gov/news/press/2009pres/06/20090624a.html>.

⁴ U.S. Dep't of Health & Human Servs., *Turning Up the HEAT to Stop Medicare and Medicaid Fraud, Background on the Health Care Fraud Prevention & Enforcement Action Team*, <http://www.hhs.gov/stop/medicarefraud/background.html>.

- to highlight the practices of those healthcare providers who successfully end waste and fraud as an example for others to follow.⁵

Federal agencies will additionally find an easier time securing criminal convictions by utilizing the recently-passed Fraud Enforcement and Recovery Act (FERA),⁶ which makes significant changes to the False Claims Act by casting a broader net to nab individuals and healthcare facilities suspected of fraud.

Further, two bills were introduced in the United States Congress earlier this year to step up efforts to combat fraud and abuse in the Medicare and Medicaid programs. The Seniors and Taxpayers Obligation Protection Act (STOP) would prohibit the use of Social Security numbers as the beneficiary identifier on Medicare cards and seek to improve HHS's fraud detection methods and scrutinize billing statements.⁷ Senators Mel Martinez (R, Fla.) and John Cornyn (R, Texas) introduced the legislation as well as the Medicaid Accountability Through Transparency Act.⁸ Under that bill, the Secretary of HHS would be required to publicly disclose Medicaid payment data that the agency collected by posting the information on an easy-to-use website and imposing a \$25,000 per day penalty for any period the Secretary finds that a state has not fully complied with the data collection requirements.⁹

Though it is doubtful that both pieces of legislation will see a vote this month, the strike force teams are doing their part to curb fraud and abuse. A sampling of recent news related to arrests, settlements, and convictions, is below.

New York's Medicaid Fraud Settlement

In response to two *qui tam* lawsuits filed by a private individual under the federal False Claims Act against New York for suspected fraudulent billing practices, the State and New York City agreed to pay a record \$540 million to settle allegations that they "knowingly submitted, or caused submission of," false claims for reimbursement for healthcare services provided to Medicaid-eligible children between 1990 to 2001.¹⁰

Since the early 1990s, the federal government has subsidized New York billions of dollars for services provided to children under the state's School Supportive Health Services Program and Preschool Supportive Health Services Program – programs

⁵ *Id.*

⁶ Pub. L. No. 111-21, 111th Cong. (2009), available at <http://www.gpo.gov/fdsys/pkg/PLAW-111publ21/pdf/PLAW-111publ21.pdf>; see also Craig A. Conway, *Newly Enacted Fraud Enforcement and Recovery Act Expands Liability for Healthcare Providers Under the False Claims Act*, HEALTH L. PERSPECTIVES, June 30, 2009, [https://www.law.uh.edu/healthlaw/perspectives/2009/\(CC\)%20FERA.pdf](https://www.law.uh.edu/healthlaw/perspectives/2009/(CC)%20FERA.pdf).

⁷ Chris Silva, *Bills Aim to Cut Medicare, Medicaid Fraud*, AM. MED. ASSOC. NEWS, May 22, 2009, <http://www.ama-assn.org/amednews/2009/05/18/gvse0522.htm>.

⁸ *Id.*

⁹ *Id.*

¹⁰ Chelsey Ledue, *New York to Pay Record \$540M to Settle Claims of Medicaid Fraud*, HEALTHCARE FIN. NEWS, July 22, 2009, <http://www.healthcarefinancenews.com/news/new-york-pay-record-540m-settle-claims-medicare-fraud>.

designed to assist local school districts and counties to obtain funds for covered diagnostic and health support services offered to disabled students.¹¹

New York will pay \$440 million over time, partly in cash and by releasing claims to payments withheld. New York City will pay approximately \$100 million – also to be paid over time.¹² Additionally, the state entered into a three-year Program Compliance Agreement with the Centers for Medicare and Medicaid Services (CMS) to ensure that healthcare services are properly delivered and billed for in the future.¹³

The relator who initiated the lawsuits under the False Claims Act will receive approximately \$10 million from the State’s settlement.

Los Angeles Jury Convicts Equipment Suppliers

Recently, a federal jury in Los Angeles, California, convicted the owners and operators of a durable medical equipment (DME) company that bilked the Medicare program out of nearly \$600,000.¹⁴ Owners of CHH Medical Supply, Gevork Kartashyan and Eliza Shurabalyan, were found guilty of conspiracy to commit health care fraud and committing health care fraud by billing Medicare for medically unnecessary power wheelchairs and accessories.¹⁵

Testimony revealed that elderly Medicare beneficiaries were recruited and taken to Los Angeles-area medical clinics where they were asked for, and gave, their Medicare numbers and other personal information.¹⁶ The clinics, in turn, would generate fraudulent prescriptions for power wheelchairs that the “patients” did not need or request. The prescriptions were then sold to CHH Medical Supply that would “fill” the prescriptions and bill Medicare.¹⁷

A testifying government witness told the jury that Kartashyan would come into one of the clinics, pick up the prescriptions, and sign false forms stating that the beneficiaries’ homes were appropriate for the use of a power wheelchair – though no home assessment was ever made.¹⁸ Additionally, five physicians testified they never authorized or approved the phony prescriptions written under their names; three testified they had never worked in any of the medical clinics listed on the prescription pads.

Charges Made Against 53 Doctors in Detroit

¹¹ *Id.*

¹² *Id.*

¹³ *Id.*

¹⁴ U.S. Dep’t of Health & Human Servs., Press Release, *Los Angeles Jury Convicts Equipment Suppliers of Medicare Fraud*, July 17, 2009, <http://www.hhs.gov/news/press/2009pres/07/20090717e.html>.

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

In late June, 53 individuals were indicted for schemes to bill millions in false Medicare claims to the federal government.¹⁹ According to the indictments, the defendants submitted claims to Medicare for treatments and services that were medically unnecessary or never performed.²⁰

Two primary areas of providers were targeted – infusion therapy and physical/occupational therapy facilities. Some “patients” may have been in on the scam as well. Indictments allege that some beneficiaries accepted cash kickbacks in exchange for the right to have providers use their names and information on forms stating they received the alleged treatments.²¹ Collectively, physicians, medical assistants, patients, company owners and executives charged are accused of conspiring to submit more than \$50 million in false claims.²²

Miami Residents Charged and Physician Sentenced

A Miami physician was sentenced in June to 97 months in prison and ordered to pay nearly \$9 million in restitution for his role in a \$10 million Medicare fraud scheme involving HIV infusion clinics.²³ Dr. Roberto Rodriguez, along with four others already sentenced for the crime, worked at Midway Medical Center, Inc., a clinic specializing in the treatment of patients with HIV.²⁴ Most of the fraudulent claims resulted from treatments for a diagnosis of thrombocytopenia, a disorder involving a low count of platelets in the blood.²⁵ However, none of the patients treated at Midway actually had low blood platelet counts. Rodriguez admitted to using chemists to manipulate patients’ blood samples to make it appear that each had low platelet levels as well as ordering medications for patients to be treated for thrombocytopenia despite having knowledge of the falsified laboratory test results.²⁶

Additionally, eight Miami residents were indicted in a separate \$22 million scheme involving home health care agencies that recruited Medicare beneficiaries and paid them cash kickbacks in exchange for the right to use their personal information to bill for

¹⁹ U.S. Dep’t of Health & Human Servs., Press Release, *Medicare Fraud Strike Force Operations Lead to Charges Against 53 Doctors, Health Care Executives and Beneficiaries for More Than \$50 Million in Alleged False Billing in Detroit*, June 24, 2009, <http://www.hhs.gov/news/press/2009pres/06/20090624a.html>.

²⁰ *Id.*

²¹ *Id.*

²² *Id.*

²³ U.S. Dep’t of Health & Human Servs., Press Release, *Miami Physician Sentenced to 97 Months in Prison for Role in \$10 Million Medicare Fraud Scheme*, June 29, 2009, <http://www.hhs.gov/news/press/2009pres/06/20090629b.html>.

²⁴ *Id.*; see also Chelsey Ledue, *Four Miami-area Residents Sentenced in \$10M Medicare Fraud*, HEALTHCARE FIN. NEWS, June 8, 2009, <http://www.healthcarefinancenews.com/news/four-miami-area-residents-sentenced-10m-medicare-fraud-scheme>.

²⁵ *Id.*

²⁶ *Id.*

services that were never provided.²⁷ Owners and operators of ABC Home Health Care, Inc., allegedly billed more than \$17 million to the Medicare program for services never performed between January 2006 to December 2008; the company received \$11 million in Medicare payments.²⁸ Similarly, another company, Florida Home Health Care Providers, Inc., received more than \$4 million in the form of Medicare reimbursements for false claims resulting from falsified tests and medical records.²⁹

Conclusion

Health care fraud costs American taxpayers an estimated \$60 billion annually and further adds frustration to a healthcare system in need of overhaul. Those healthcare providers with questionable billing practices or with clear malice in defrauding the government should consider altering their methods or they may find federal agents soon knocking on the front door.

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<http://www.law.uh.edu/healthlaw/perspectives/homepage.asp>

²⁷ U.S. Dep't of Health & Human Servs., Press Release, *Eight Miami-Area Residents Charged in \$22 Million Medicare Fraud Scheme Involving Home Health Care Agencies*, June 26, 2009, <http://www.hhs.gov/news/press/2009pres/06/20090626a.html>.

²⁸ *Id.*

²⁹ *Id.*