



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**

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**Testimony Before the United States House of Representatives  
Committee on Ways and Means  
*Subcommittee on Oversight***

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**Health Care Fraud Investigations**

Testimony of:

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Good morning, Chairman Roskam, Ranking Member Lewis, and distinguished Members of the Subcommittee. I am Abhijit Dixit, a Special Agent with the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG). I appreciate this opportunity to describe the work that my fellow OIG agents and I in Detroit do to protect Medicare and Medicaid beneficiaries and to fight health care fraud.

I am here this morning to give you a field agent's perspective. I investigate medical providers that defraud Federal health care programs through the submission of false claims or other prohibited acts and, in doing so, place the safety and well-being of program beneficiaries at risk. Today, my testimony will describe both the manner in which OIG investigates allegations of health care fraud and the schemes that present continued threats to the integrity of the Medicare and Medicaid programs.

The work of OIG's special agents has a valuable and positive impact across the country. During fiscal years 2013 through 2015, OIG investigations nationally resulted in more than \$10.9 billion in investigative receivables, or dollars ordered or agreed to be paid to Government programs as a result of criminal, civil, or administrative judgments or settlements. In addition, our investigations led to 2,856 criminal actions, 1,447 civil actions, and 11,343 program exclusions.<sup>1</sup> Beyond these statistical accomplishments, OIG special agents are on the front lines, interacting daily with Medicare and Medicaid beneficiaries and providers. Though difficult to quantify, a valuable part of our work is protecting beneficiaries from harm.

It is important to point out that our special agents' work is typically conducted in partnership with other Federal and State agencies as well as the private sector. We partner with other investigators, auditors, evaluators, and attorneys in OIG and in other agencies to most effectively investigate and prosecute fraud. These partnerships are invaluable in our enforcement successes. For example, OIG has strong relationships with Medicaid Fraud Control Units (MFCUs), which are State-level investigative units with which we work on the majority of our Medicaid investigations. As a former MFCU investigator, I know firsthand the benefits of leveraging the specialized knowledge of agents in each State's Medicaid program. Through several task forces and other partnerships we often work hand in hand with multiple Federal agencies.

OIG also participates in Medicare Fraud Strike Force teams that combine the resources of Federal, State and local law enforcement entities to prevent and combat health care fraud across the country. The Medicare Strike Force effort began in March 2007 and expanded to seven cities, including Detroit, in 2009. The Strike Force, which now operates in nine locations, has charged more than 2,900 defendants who collectively have falsely billed the Medicare program over \$8.9 billion. A clear example of success came in June 2016, when I was among

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<sup>1</sup> OIG has the authority to exclude individuals and entities from federally funded health care programs. The effect of an exclusion is that no payment will be made by any Federal health care program for any items or services furnished, ordered or prescribed by an excluded individual or entity.

approximately 350 OIG agents who partnered with more than 1,000 other law enforcement personnel to execute the largest health care fraud takedown in history. The takedown, led by the Medicare Fraud Strike Force, resulted in criminal and civil charges against 301 individuals, including 61 doctors, nurses, and other licensed medical professionals, for their alleged participation in health care fraud schemes involving approximately \$900 million in false billings.

Through coordinated enforcement efforts across the country, including those of the Strike Force teams, criminal prosecutions and monetary recoveries have increased while we have seen a measurable decrease in payments for certain medical services targeted by fraud schemes. We believe that one measure of success is that annual Medicare payments for home health services nationally decreased by more than \$1 billion since calendar year 2010. In Detroit, payments to home health care agencies have decreased by \$100 million annually. These declines followed targeted enforcement activities as well as policy changes, such as the implementation of temporary moratoriums on new home health agency enrollments, increased payment suspensions, and payment reforms. OIG identifies systemic vulnerabilities and makes recommendations to the Centers for Medicare & Medicaid Services (CMS) to better prevent fraud. In the case of moratoriums, OIG provides information and CMS evaluates the existing provider and supplier base, including factors such as how a temporary moratorium will affect access to care. Despite this measurable success, more work remains in Detroit and across the nation.

## **OIG USES SOPHISTICATED DATA ANALYTICS AND REAL-TIME FIELD INTELLIGENCE TO ENHANCE ENFORCEMENT EFFORTS**

The schemes used to steal money from Medicare and Medicaid are multifaceted. Schemes can be as simple as billing for a service not actually performed, or as complex as an organized criminal enterprise. The perpetrators of these frauds can range from highly respected physicians to individuals with no prior experience in the health care industry. Regardless, they all have one thing in common – greed. Unscrupulous providers motivated by greed often put profit before patients’ health and safety, creating potentially dangerous patient care environments.

Health care fraud cases share similarities. However, no two cases are exactly the same, and each investigation presents unique challenges. OIG receives complaints or investigative leads from a variety of sources, including the OIG hotline, law enforcement partners, beneficiaries, providers, and informants. Traditional means of identifying fraud include conducting interviews of cooperating witnesses and surveillance.

To accomplish our mission, OIG employs data analytics and real-time field intelligence to detect and investigate program fraud and to target our resources for maximum impact. OIG is a leader in the use of data analytics, employing a dedicated data analytics unit. Gathering claims data and other electronic information from multiple sources and efficiently and effectively merging that information into a manageable and usable format is a highly specialized skill. Our special agents have direct access to Medicare claims data and use innovative methods to analyze billions of data points to identify trends that may indicate fraud, geographical hot spots, emerging schemes, and individual providers of concern. We also use data throughout an investigation to identify

potential witnesses or co-conspirators and conduct interviews as efficiently and effectively as possible.

It should be noted that although data analytics is important and helpful, it is necessary to combine the insights gained from it with valuable field intelligence. For example, the data alone may not reveal the complex structure of a criminal enterprise. Data analytics may not determine whether kickbacks are being paid, services are being rendered, or patients are being harmed. Traditional field intelligence obtained by investigators through witness and subject interviews, execution of search warrants, surveillance, and evidence review is still critical in revealing the scope and nature of a fraud scheme.

## **OIG PRIORITIZES FRAUD CASES THAT JEOPARDIZE PATIENTS' HEALTH OR SAFETY**

I would like to emphasize that Medicare and Medicaid fraud affects more than the public coffers. When fraud is committed, beneficiaries can suffer harm and neglect.

OIG addresses all allegations of fraud as swiftly as possible by allocating scarce investigator time on the basis of available information. However, certain allegations of patient harm further heighten the sense of urgency, and we mobilize our teams and work around the clock to protect patients. An example of this, in which I was personally involved, is the case of a Detroit-area hematologist-oncologist, Dr. Farid Fata, sentenced last year to serve 45 years in prison. Dr. Fata used false cancer diagnoses and unwarranted, dangerous treatments as tools to steal millions of dollars from Medicare and private insurance companies.

When the Department of Justice (DOJ) received a complaint from Dr. Fata's office manager, OIG and our law enforcement partners acted immediately. We simultaneously began the initial phase of the investigation—determining whether the allegations were credible—and took steps to protect the potentially affected patients.

From the investigative perspective, we retrieved and analyzed near real-time claims data to identify witnesses who could give us more information. We also began deploying traditional law enforcement techniques, which included conducting surveillance, interviewing key witnesses, serving subpoenas, and reviewing documents. We established a command post as a single point for investigators to relay information immediately to a prosecution team. All available special agents were given assignments and worked through the weekend to identify the credibility of the allegation. Once we were able to develop enough evidence to corroborate the initial allegation, we obtained several warrants. Before executing any warrant, we develop an operational plan. In this case, the plan included information about the subject to be arrested, his criminal history and background; team assignments; emergency information, including the address of the nearest hospital; and detailed information about the location where the search and arrest warrants would be executed. A judge signed the warrants at approximately 4 a.m. On the same day, just after 6 a.m., the doctor was arrested and six search warrants were executed.

OIG special agents are trained to identify and address potential patient harm. Using this training, I worked with the law enforcement team before the operation was executed to protect patients in many ways beyond the criminal investigation and prosecution. We deployed additional staff to each operational site where warrants were executed to provide information directly to patients and the public. OIG agents and other law enforcement personnel referred affected patients to a specially created victim-assistance hotline, staffed by DOJ, which provided around-the-clock information.

We accomplished all of this—the initial phase of the investigation, the arrest, and the patient protection efforts—in just 5 days.

Additionally, CMS suspended payments to Dr. Fata. As evidence was uncovered, it became clear that patient-related decisions were made to maximize reimbursement rather than to advance the best interests of the patient. Dr. Fata pleaded guilty to health care fraud and other charges for his role in this scheme that included administering medically unnecessary infusions or injections to 553 individual patients and submitting to Medicare and private insurance companies approximately \$34 million in fraudulent claims.

While such stark examples of direct physical harm to patients are rare, the case of Dr. Fata is far from the only example of a provider subjecting patients to significant harm in the pursuit of profit.

Dr. Aria Sabit, another Detroit-area physician, performed unnecessary, invasive spinal surgeries and implanted costly and unnecessary medical devices, all at the expense of his patients' health and welfare. Dr. Sabit, a neurosurgeon, lied to patients about the procedures' medical necessity and what he actually did. He persuaded patients to undergo spinal fusion surgery that included specific medical devices designed to stabilize and strengthen the spine. But he did not perform that surgery. Instead, Dr. Sabit performed a different operation not related to lumbar and thoracic fusion. He also sometimes billed for implants not provided and falsified operative reports that he knew would later be used to support his fraudulent insurance claims. Dr. Sabit subsequently billed Medicare, Medicaid and private insurance companies \$11 million for those fraudulent services. In some cases, patients experienced serious bodily injury and ended up in worse condition than before the surgery. Dr. Sabit has pleaded guilty in two separate criminal cases and awaits sentencing.

Other examples, which are found in numerous OIG investigations, include physicians writing medically unnecessary controlled substance prescriptions for pseudo-patients in exchange for cash or submission by a patient to medically unnecessary services – for which the provider would bill. Such medically unnecessary services include diagnostic testing, uncomfortable nerve conduction studies, or monthly office visits.

## **CERTAIN HEALTH CARE PROGRAMS ARE CONSISTENTLY TARGETS FOR FRAUD**

The fraud schemes we see in Detroit mirror those across the country, but with distinct variations. Often, fraud schemes evolve and migrate from one region of the country to another. To avoid

detection as enforcement increases, either through law enforcement action or policy and payment changes, criminal networks may conduct geographical research to “test” combinations of billing codes identifying payment edits before the “breakout” billing and subsequent submission of a high number of false claims. The “breakout” billing is often visible through targeted data analytics, and OIG special agents work with our multidiscipline experts to identify these spikes early to prevent further fraud. Several organized criminal enterprises migrated from Miami, which is often considered “ground zero” for health care fraud, to Detroit. We have closely coordinated with our Miami office to target these schemes. Program areas susceptible to widespread fraud include, among others, home- and community—based services, and prescription drugs. OIG focuses on these areas and they represent a significant portion of our enforcement efforts, both in Detroit and nationally.

### **OIG PRIORITY: ENFORCEMENT AND PREVENTION OF HOME- AND COMMUNITY-BASED SERVICES FRAUD**

Home- and community-based services, including Medicare home health and Medicaid personal care services (PCS), help beneficiaries continue to live in their homes and avoid costly and disruptive facility-based care. Although OIG has had significant successes in combatting fraud in these programs, we continue to identify and investigate fraudulent providers in Medicare Strike Force areas, including Detroit. OIG home health investigations (which is where I have had the most experience) have resulted in more than 350 criminal and civil actions and \$975 million in investigative receivables for fiscal years 2011 - 2015.

Home health fraud schemes generally involve billing for services that are not medically necessary and/or not provided. For example, in April 2016 Dr. Jacques Roy and three home health agency (HHA) owners were convicted for their roles in a \$375 million fraud scheme. At the time, this was the nation’s largest home health care fraud carried out by a single doctor. As part of the scheme, the perpetrators recruited patients at homeless shelters, in grocery stores, and by door-to-door solicitation to sign up for Medicare home health services. Dr. Roy falsely certified, and later recertified, beneficiaries as being eligible to receive home health care. His office staff falsified medical documentation to support the eligibility certifications and support billing for services that were never provided. Dr. Roy also visited some of the recruited patients’ homes and then billed Medicare for unnecessary home visits. Two additional HHA owners and an office manager pleaded guilty for their roles in this scheme. Dr. Roy awaits sentencing.

OIG identified Dr. Roy following proactive data analytics targeting suspicious billing. The physician’s office processed and approved certifications for 11,000 unique Medicare beneficiaries from more than 500 different home health agencies. Typical physicians refer fewer than 100 patients for home health services. Our data analysis identified this physician as an extreme outlier, but that was only the beginning of this investigation. The massive scope, multiple co-conspirators, and falsified records meant the dedication of significant OIG investigative resources to protect patients and taxpayer dollars. During execution of the search warrant in this case, the amount of physical and digital evidence collected was unprecedented, and presented challenges to the investigative team. Arrangements were made to store the over

900 boxes seized, and nearly all of OIG's digital investigations staff were required to handle the 40 terabytes of data seized.

The investigation of six metro Detroit-area HHAs is another example in Michigan involving kickbacks and the billing of Medicare for nonrendered or medically unnecessary home health services. Our investigations resulted in the convictions of 14 physicians, HHA owners, and patient recruiters. The investigation revealed that beneficiaries' personal information was acquired by patient recruiters. In exchange for their personal information, the recruiters gave the beneficiaries cash and illicit prescription drugs. One of the HHA owners, Naseem Minhas, charged with \$4 million in fraudulent billing, admitted that in addition to paying kickbacks, he assisted in creating false patient files to make it appear as though the patients needed and received the services. To date, these convictions have resulted in just over 36 years in prison sentences.

OIG is committed to protecting the financial integrity of home- and community-based services and the health and welfare of the people served. We previously published a personal care services [Portfolio](#)<sup>2</sup> and recently published a home health [online Portfolio](#),<sup>3</sup> which pulls together information about our body of home health work, including enforcement actions, reports, and recommendations.

## **OIG PRIORITY: ENFORCEMENT AND PREVENTION OF PRESCRIPTION DRUG FRAUD**

Another priority for OIG is enforcement action against and prevention of prescription drug fraud. Prescription drug abuse is a rapidly growing national health care problem, and our nation is in the midst of an unprecedented opioid epidemic.<sup>4</sup> As of early September 2016, OIG had 678 pending complaints and cases involving Medicare Part D, which represents a 152-percent increase in the last 5 years.

Medicare and Medicaid prescription drug diversion—the redirection of prescription drugs for an illegal purpose—is a serious component of this epidemic. Although the diversion of controlled substances, such as opioids, is of paramount concern, the diversion of noncontrolled substances is becoming more common. In these cases, noncontrolled substances are combined with opioids and other controlled substances to exaggerate the user's "high" – making noncontrolled drugs susceptible to abuse. Fraud related to both controlled and noncontrolled drugs results in significant financial losses to Medicare and Medicaid and, more importantly, may also result in patient harm and even death.

In one example of prescription drug diversion, a Michigan pharmacist and a network of pharmacies were among 37 defendants convicted for their roles in a widespread scheme to defraud Medicare and Medicaid of nearly \$58 million. According to the indictment, the

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<sup>2</sup> [Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement](#) (OIG-12-12-01)

<sup>3</sup> [HHS OIG Online Portfolio: Home Health](#)

<sup>4</sup> Centers for Disease Control and Prevention, [Prescription Painkiller Overdoses at Epidemic Levels](#) [press release], Nov. 1, 2011.

pharmacist either owned or controlled 26 pharmacies, although he concealed his ownership and control over many years through the use of “straw” owners. The pharmacist offered and paid kickbacks, bribes, and other inducements to prescribers who wrote fraudulent prescriptions for patients under Medicare, Medicaid, and private insurance, and directed the patients to fill the prescriptions at one of his pharmacies.

The scheme was detected when OIG special agents reviewed prescription drug claims data for a physician under investigation in another matter. The network of pharmacies began to emerge as an outlier. OIG joined forces with other law enforcement agents who had also identified the pharmacy network as suspicious. The investigation involved examining records for evidence of kickback payments, interviewing witnesses and other cooperators, surveillance, and the execution of multiple arrest and search warrants.

Evidence revealed that the pharmacist and those working for him billed Medicare and other insurers for dispensing the medications, despite the fact that the medications were medically unnecessary and/or were never provided. From January 2009 to August 2011, his pharmacies dispensed approximately 250,000 doses of OxyContin, 4.6 million doses of Vicodin, 1.5 million doses of Xanax, and 6,100 pint bottles of codeine cough syrup.

The pharmacist was sentenced to 17 years in prison and ordered to pay \$18.9 million in restitution. In addition, 14 other pharmacists, 9 doctors, 6 business associates, 4 patient recruiters/drug dealers and 3 pharmacy technicians were sentenced to a combined 92½ years in prison, and ordered to pay collectively more than \$84 million in restitution.

Combatting prescription drug fraud continues to be an enforcement priority, and OIG will remain vigilant in investigating emerging trends.

## **CONCLUSION**

In conclusion, I would like to underscore OIG’s commitment to protecting program beneficiaries and fighting health care fraud. The highly specialized investigative work of our special agents, combined with cutting edge data analytics, continue to prove effective in making a valuable and positive impact. By leveraging partnerships and building on the success of the Medicare Strike Force, OIG’s investigators will continue to prevent, detect, and fight fraud.

It has been a pleasure to discuss our work and to describe some of our recent successes in protecting Medicare and Medicaid beneficiaries from harm and taxpayer dollars from theft. Thank you again, for inviting OIG to speak with the Subcommittee today. I hope that our work and this testimony will assist you in your oversight efforts. I would be happy to answer any of your questions.