



Testimony before the United States House of Representatives

Committee on Energy and Commerce

Subcommittee on Oversight & Investigations

**“Waste, Fraud and Abuse: A Continuing Threat to Medicare and
Medicaid”**

Testimony of:

**Omar Perez
Assistant Special Agent in Charge
Office of Inspector General
U.S. Department of Health & Human Services**

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2322 Rayburn House Office Building



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Good morning Chairman Stearns, Ranking Member DeGette, and distinguished members of the Subcommittee. I am Omar Perez, an Assistant Special Agent in Charge (ASAC) with the U.S. Department of Health & Human Services' (HHS) Office of Inspector General (OIG). I am stationed in the Miami Regional Office, and currently supervise Agents assigned to the Medicare Fraud Strike Force. I was formerly a member of one of the Strike Force teams prior to my assuming the position of ASAC. I am honored to have the opportunity to discuss OIG's efforts in combating Medicare and Medicaid fraud.

I am here this morning to tell you what our agents experience as criminal investigators on the front-line in the fight against health care fraud. Although the vast majority of Medicare providers are honest, my job is to focus on those who steal from the program. My squad is actively engaged in investigating criminal health care fraud, executing search and arrest warrants, seizing bank accounts, and providing Grand Jury testimony in the pursuit of criminal indictments.

In South Florida, Medicare fraud is not only perpetrated by independent, scattered groups, but also by competitive, organized businesses complete with hierarchies and opportunities for advancement. Medicare fraud is discussed openly on the streets and is accepted as a safe and easy way to get rich quick.

Who commits this fraud? People from all walks of life—they say it's easy money and it's safer than dealing drugs. I see people who never finished high school living lavish lifestyles, making anywhere from \$100,000 to millions of dollars a year by committing Medicare fraud. The money involved is staggering. We see business owners, health care providers and suppliers, doctors, and Medicare beneficiaries participating in the fraud. We also see drug dealers and organized criminal enterprises defrauding the system.

How much money is involved? Way too much! As an example, I will tell you a little later about an investigation I supervise in which over \$200 million was billed to Medicare in just 2 years.

In my testimony today, I will describe a typical Medicare fraud scheme that we investigate in Miami. I will then provide an overview of the Miami Strike Force investigative approach from an agent's perspective. I will share examples of Miami Strike Force success stories. Finally, I will discuss the evolution of fraud in South Florida.

COMMON DURABLE MEDICAL EQUIPMENT FRAUD SCHEMES PRE-STRIKE FORCE

Prior to the start of the Strike Force, South Florida was riddled with sham durable medical equipment (DME) companies. Some of these companies started out as legitimate operations with a Medicare billing number; however, they were unsuccessful as the market was saturated with illegitimate DME companies. As a result, these companies were sold and, all too often, their new owner(s) had one idea in mind: steal from Medicare.

Once in the hands of criminals, these companies no longer provided legitimate services. In order to perpetrate the fraud, "nominee owners"¹ were recruited. The names of these nominee owners were placed on corporate documents, lease agreements, and corporate bank accounts. Those perpetrating the fraud then obtained lists of stolen Medicare beneficiary information which were compiled by individuals with access to patient information, such as employees of hospitals, clinics, and physicians' offices. The criminals also obtained lists of stolen Unique Physician Identification Numbers (UPIN) assigned to physicians by the Centers for Medicare & Medicaid Services (CMS). UPINs are essential to the completion of a Medicare claim for reimbursement. With these two key pieces of information, the nominee owners would submit fraudulent claims to Medicare for DME that was never provided. The types of equipment ranged from nebulizers and corresponding medications, to incontinence supplies, to motorized wheelchairs.

Once CMS paid the claims and deposited money into the company's bank account, it was withdrawn within days using multiple check cashers. The idea was to deplete the account so that once Medicare discovered the fraudulent billing, which could take 6 months to 1 year, there would be no money in the account.

MIAMI STRIKE FORCE APPROACH TO COMBATING FRAUD

The DME fraud schemes described above were executed within a matter of months. After billing Medicare for millions of dollars, companies would change ownership, bill Medicare again for millions of dollars, close, and simply take over another company and repeat the process in another location. By the time traditional investigative referral methods came to fruition, criminals had absconded with millions of taxpayer dollars.

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, established by Secretary Kathleen Sebelius and Attorney General Eric Holder in May 2009, is a joint effort by HHS and DOJ to leverage resources and expertise to prevent fraud, waste, and abuse in Medicare and Medicaid. A critical component of HEAT is the Medicare Fraud Strike Force.

¹ A nominee owner is an individual who is recruited and paid by the true owner to be the owner of record for a DME company. This process occurs to protect the identity of the true owner.

A streamlined investigative approach was created for Strike Force investigations. The Strike Force model is a collaborative effort between the Department of Justice (DOJ) and HHS. Each Strike Force team includes agents from HHS OIG and the Federal Bureau of Investigation, as well as attorneys from DOJ. The teams are supported by Investigative Analysts, as well as CMS program experts and contractors. Miami has 10 Strike Force teams dedicated to investigating the wide array of Medicare fraud such as HIV infusion therapy, physical and occupational therapy, DME, home health agencies, and Community Mental Health Centers to name a few.

The individual investigations generally follow a model that has proved highly successful in these fraud schemes. The model includes the following steps: (1) analyze and evaluate claims data; (2) obtain the Medicare enrollment application; (3) identify the medical biller; (4) identify and obtain bank information; and (5) identify the “true” owner of the Medicare provider that is under investigation.

Analyze and Evaluate Claims Data

We now have the ability to stop the payment of a significant amount of money and catch the criminals before they and the money disappear. Strike Force team members receive Medicare billing data gleaned from a wide variety of CMS data systems. We analyze the data to identify aberrant billing patterns. Before Strike Force teams were initiated, the referrals we received contained billing data that were typically between 6 months to 1 year old. Today, the data we receive provide billing information that is only 2 to 3 weeks old. In South Florida, as elsewhere, criminals can receive several hundred thousand dollars in fraudulent payments within a matter of weeks. The ability to retrieve recent data allows us to potentially obtain evidence immediately to substantiate fraudulent activity. The claims data can help us identify important information in assessing whether a fraudulent scheme is underway, including:

- total amount paid
- dates of service
- referring/ordering physicians
- beneficiaries
- claim dates
- types of procedures billed
- place of service
- provider banking information, and
- ownership status.

This process is called developing an investigative snapshot² of the suspected fraudulent activity.

² “Snapshot” refers to an excerpt of a provider’s or supplier’s billing history that includes total amount billed and paid, claims denied, patient name, referring physicians, procedural codes billed, dates of service and place of service.

Obtain the Medicare Enrollment Application and Other Data

Obtaining the Medicare enrollment application is extremely important because it identifies the registered owner, his or her financial institution, and the authorized medical billing representative. For investigators, this information can generate countless leads to other co-conspirators involved in the fraudulent activity.

Identify the Medicare Medical Biller

The Medicare billing process begins when the medical biller electronically submits the patient's information to a Medicare claims contractor for processing and reimbursement. The medical biller could be an employee of the fraudulent company and/or a contracted third party. It is important for investigators to interview the medical biller to determine his or her level of complicity, if any, and identify who provided the billing information.

Identify the Bank Account and Financial Institution of the Fraudulent Business

A critical investigative step is determining the true owner of the fraudulent provider's bank account. In many instances, the true owner is not the individual who opened the bank account, withdrew or transferred funds, and/or cashed the Medicare checks. It is a significant step for investigators to identify and interview all individuals with signatory control over these accounts.

Identify the "true" owner of the clinic and/or DME company

Strike Force members utilize commercial databases, bank account data, and informants in an effort to identify the true owners of the company. Once the true owner is identified, Strike Force members will attempt to interview the true owner.

Typically, a nominee owner is paid \$10,000 to \$20,000 for his or her role. Our sources have told us that nominee owners have been recruited in other countries and travel to South Florida solely for this purpose. After being paid, they return to their native countries.

MIAMI STRIKE FORCE SUCCESS STORIES

I offer the following examples that highlight the successes of our streamlined investigative strategy:

One of our Agents received information from a confidential source that a DME company was submitting fraudulent claims. Through data analysis, we saw that there was an aberrant billing spike just after a corporate change of ownership took place: \$1.5 million billed in just 3 weeks. Further data analysis showed that this company was billing for about 100 patients that another company we have under investigation was also billing for.

With a few interviews, the Agents corroborated that fraud was taking place, and within 30 days we were able to arrest our target. Using this approach, we were able to prevent any Medicare funds from reaching the subject's hands. After the arrest, the Agents learned that he was using a false identity and was about to purchase yet another company. The investigation continues.

In another example, OIG Agents received information from a confidential source that a corporation owning several Community Mental Health Centers (CMHC) was billing Medicare for services that patients were not receiving or did not qualify for to the tune of \$200 million. The owner and managers of this corporation offered and paid kickbacks and bribes to patient recruiters to recruit Medicare beneficiaries to attend the corporation's CMHCs and allow Medicare to be billed for services purportedly provided to them. The patients in turn were paid by the patient recruiters. Data queries were performed, interviews conducted, and within 45 days we secured a criminal indictment charging the center's owner and managers with health care fraud. In October of last year, we executed five arrest warrants and seven search warrants.

The information obtained in the CMHC investigation led to another indictment this year. In February, our enforcement operation resulted in the arrest of 20 individuals ranging from physicians, therapists, clinic directors, patient recruiters, and money launderers. Physicians purportedly falsified medical records, and clinic directors allegedly directed the patient recruiters and money launderers. As part of this operation, we reached out to seven other OIGs to assist in the arrest operation using the mutual assistance program previously mentioned by Deputy Inspector General for Investigations Roy. Utilizing this collaborative and cost-efficient approach, we were able to arrest 60 subjects in Miami connected to stealing millions of dollars from the Medicare trust fund. This investigation is ongoing.

THE EVOLUTION OF FRAUD IN SOUTH FLORIDA

In many instances, criminals have shifted their schemes from purchasing legitimate DME companies to instead establishing storefront shams. The storefronts are set up by criminals who have the required equipment to pass Medicare onsite inspections. Once the Medicare provider number has been issued, the individuals pick up their equipment and all that remains is an empty storefront.

Some criminals create additional layers to shield the true owners to counter Strike Force tactics. Prior to Strike Force operations, the true owner was most likely an associate of the nominee owner. Now there are many levels to their criminal enterprises; each level operating independently of the others but controlled by the same person(s).

We found that criminals are now migrating to other services within the Medicare program to perpetrate their fraud. Other services impacted include home health, community mental health, and physical and occupational therapy. OIG is aggressively addressing these areas. Historically, Medicare beneficiaries and physicians were not

typically involved in these types of criminal enterprise. Now we know that in more and more cases both are getting paid to participate in fraud.

CONCLUSION

The investigative approach and success stories referenced today represent the dedication and commitment of all OIG Special Agents and our collaborative partners in the fight against fraud within the Medicare and Medicaid insurance programs. The HEAT initiative illustrates how combined resources, technology, and collaboration can be synthesized to combat health care fraud to protect vulnerable Americans.

Thank you for the opportunity to discuss Strike Force operations in South Florida, and the strategies and investigative methods utilized to protect the interest of all taxpayers. I would be happy to answer any questions that the Subcommittee may have.