2016 NATIONAL HEALTH CARE FRAUD TAKEDOWN

The Department of Health and Human Services Office of Inspector General, along with our state and federal law enforcement partners, participated in the **largest health care fraud takedown in history** in June 2016. Approximately **300 defendants in 36 judicial districts** were charged for their alleged participation in Medicare and Medicaid fraud schemes involving about **$900 million in false billings** to these programs.

These takedowns protect and deter fraud of the Medicare and Medicaid programs that millions of Americans rely on – 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 $1.00 spent on health care related fraud and abuse investigations in the last three years, more than $6.10 was recovered.

Scope

- Doctors and other medical professionals are responsible for a significant portion of the schemes in this takedown. More than **60 licensed medical professionals, including 30 doctors,** were charged in this takedown.
- The alleged schemes involve fraudulent billing to Medicare and/or Medicaid for treatments or services that were medically unnecessary or were never provided at all, including: home health care services, durable medical equipment, and pharmacy fraud.
- More than **1000 law enforcement personnel** took part in this operation, including more than **350 OIG special agents**.

NATIONAL HEALTH CARE FRAUD TAKEDOWNS		
Date	**# of People Charged**	**Amount of Loss**
July 2010	94	$251 million
February 2011	111	$225 million
September 2011	91	$295 million
May 2012	107	$452 million
October 2012	91	$430 million
May 2013	89	$223 million
May 2014	90	$260 million
June 2015	243	$712 million
June 2016	~275	~ $800 million
Total	**App. 1,200**	**Over $3.5 billion**

Schemes

- Medicare fraud schemes are regional and viral. Criminals copy fraud techniques they learn from other criminals in their communities.
- HHS OIG and law enforcement partners investigate and, when appropriate, will shut down the fraud quickly and responsibly.
- In one noteworthy fraud scheme in this takedown, **Dr. Aleksandr Pikus and his co-conspirators allegedly billed Medicare and Medicaid $86 million for medically unnecessary physical and occupational therapy.** As alleged, this scheme was fueled by kickbacks provided to beneficiaries and ambulance drivers in order to fill these Brooklyn-area clinics.

Use of Data Analytics

- Advanced **data analytics contributed heavily to this operation's success** in identifying possible bad actors across the country. Our agents are now able to obtain and analyze billing data in real-time.
- Our use of data analytics identified the alleged fraud scheme of **Houston-based Dr. John Ramirez, who was charged in this takedown for fraudulently billing $90 million in a home health claims.** One of the nation's top Medicare Part B billers, Ramirez's home health orders accounted for more than 95 percent of his payments. He was also an outlier – that is, statistically distant from others--through the number of hours he billed in a given day compared to his peers. Learn more about home health fraud and our efforts to curb it, see our Eye on Oversight video.
- Through our **use of data, we are increasingly able to stop fraud schemes at the developmental stage**, and to prevent the schemes from spreading to other parts of the country.
- To limit the damage these fraud schemes can do, OIG coordinated in advance of this takedown with the Centers for Medicare and Medicaid Services to implement payment suspensions where appropriate for health care providers who showed credible allegations of fraud.

Administrative Enforcement Action

- OIG uses Civil Monetary Penalties Law authority to hold former owner of home health agency accountable for paying kickbacks.
- On **June 22, 2016, Tariq Chaudhry entered into a settlement agreement with OIG for $50,000 to resolve kickback allegations**. Chaudhry is a former owner of a Chicago-area home health agency (HHA). OIG contends that Chaudhry paid illegal remuneration to a Chicago physician in exchange for the physician's referral of patients for home health care services to Chaudhry's HHA. The kickback was disguised as medical director fees, when, in fact, no services were performed. OIG also contends that Chaudhry and the HHA he formerly owned made the payments to the physician through one or more of its marketer employees or contractors.