

## Strike Force Targets Medicare Fraud By Los Angeles Area Health Care Companies

by PR-NewsWire

WASHINGTON, May 8 /PRNewswire-USNewswire/ -- Eleven people have been indicted in the second phase of a targeted criminal, civil and administrative effort against individuals and health care companies that fraudulently bill the Medicare program, Assistant Attorney General of the Criminal Division Alice S. Fisher and U.S. Attorney for the Central District of California Thomas P. O'Brien announced today.

The indictments in the Central District of California resulted from the creation of a multi-agency team of federal, state and local investigators designed specifically to combat Medicare fraud through the use of real-time analysis of Medicare billing data. The first phase of the strike force began operating in Miami-Dade County on March 1, 2007, and has secured more than 100 convictions to date related to fraudulent Medicare billing.

Since phase two of strike force operations began in Los Angeles on March 1, 2008, the strike force has obtained indictments of individuals and organizations that collectively have made almost \$13 million in fraudulent claims to the Medicare program. Charges brought against the defendants in these indictments include conspiracy to commit health care fraud, advising or participating in a scheme to defraud a health care benefit program and aggravated identity theft. If convicted, many of the defendants face up to ten years in prison. All indictments also seek forfeiture of the criminal proceeds.

"The indictment of 11 defendants and execution of six warrants mark phase two of the Medicare Fraud Strike Force which focuses resources to target Medicare fraud as it is occurring. The Strike Force has been successful in recovering millions of dollars that were bilked from the Medicare program and in convicting more than 100 wrongdoers in Miami," said Assistant Attorney General of the Criminal Division Alice S. Fisher. "We are pleased to be working with our partners in Los Angeles to investigate and prosecute those who attempt to defraud the Medicare program. And I thank the leaders of the Strike Force, Kirk Ogrosky and John Kelly, as well as all the prosecutors and agents who continue to dedicate themselves to combating fraud."

"Medicare fraud is a significant problem in Southern California, which is why we have welcomed Justice Department attorneys to join forces with our health care fraud prosecutors," said United States Attorney for the Central District of California Thomas P. O'Brien. "The strike force approach to this long-running problem signals our intention to root out criminals who rob taxpayers and strip resources that should go to deserving beneficiaries of the Medicare program."

The strike forces can identify potential fraud cases for investigation and prosecution quickly through real-time analysis of billing data from Medicare Program Safeguard Contractors and claims data extracted from the Health Care Information System. In phase two, prosecutors, agents and analysts from federal law enforcement and government agencies are analyzing claims data to determine unusual billing patterns to identify possible fraudulent activity. Based on identified irregular patterns, the strike force investigates individuals and/or companies that may be involved in submitting false claims to the Medicare program.

Medicare Part B covers physician's services and outpatient care, including beneficiary access to durable medical equipment (DME) such as orthotic devices, motorized wheelchairs, hospital beds, air mattresses and trapeze bars. The Medicare program pays reimbursement on claims made by providers for DME and related medications only if medically necessary for the beneficiary's treatment and prescribed by the beneficiary's physician. To receive payment, providers either submit claims directly to the Medicare program or through a billing company.

The work of the strike force is just one step in a multi-phase enforcement and regulatory project designed to improve the quality of the industry and reduce the potential for fraud in the DME and infusion areas. The Centers for Medicare and Medicaid Services is taking steps to increase accountability and decrease the presence of fraudulent providers, resulting in better service to beneficiaries and savings of billions of dollars that might otherwise go to fraudulent businesses.

On May 8, 2008, federal agents executed four search warrants, two seizure warrants and arrested ten people in the first round of arrests resulting from phase two of the Medicare Fraud Task Force. Defendants taken into custody in today's sweep were arrested for submitting false claims to the Medicare program for wheelchairs, orthotics and other DME that was medically unnecessary and/or not provided to the beneficiaries identified in claims. All defendants arrested today were owners and operators of medical supply companies in the Los

Angeles area.

In one example, David Gabrielyan and Marina Nazarova, owners of U.S. Medtrade Co. Inc. were paid more than \$1.5 million by the Medicare program for approximately \$2 million worth of claims they falsely filed during a 13-month period. In another case of medical supply company fraud, Jesus Zamarripa, owner of Edward Medical Supply Inc. received more than \$1.1 million in claimed payments from the Medicare program in only ten months. Defendants Usik Kirakosian and Petros Odachyan claimed nearly \$3 million in durable medical supplies for beneficiaries who neither needed nor received the equipment, resulting in payments of more than \$1.2 million during the 16-month scheme.

"The commitment by the Justice Department to target individuals defrauding the Medicare Program at the expense of legitimate beneficiaries enables the FBI to conduct swift and meaningful investigations leading to arrests," said Salvador Hernandez, Assistant Director in Charge of the FBI in Los Angeles. "We will continue to work with the Strike Force in Los Angeles to combat the considerable crime problem involving health care fraud."

"Working closely with important federal, state and local law enforcement partners in Los Angeles, we have now successfully replicated the Medicare Strike Force initiative that was first used last year in Florida," said Daniel R. Levinson, Inspector General for the Department of Health and Human Services. "This collaborative enforcement model is an effective way to direct investigative resources toward illegal activities and preserve the integrity of the Medicare program."

On May 9, 2007, the Miami Strike Force was publicly announced, following the arrest of 28 defendants by FBI and U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) agents the previous day. Phase one of strike force operations in Miami-Dade County which ran from March 1 to Sept. 30, 2007, led to the indictment of 130 individual defendants in 76 cases, resulting in 101 convictions to date. Eleven convictions resulted from jury verdicts, 90 convictions came as the result of pleas, 13 individuals remain fugitives and the remainder of the 130 defendants are awaiting trial.

In Miami, fraudulent billings to Medicare in strike force-related cases have exceeded \$420 million, including \$195 million billed in fraudulent infusion therapy claims, \$209 million billed in fraudulent DME claims and \$16 million billed in fraudulent pharmaceutical claims. To date, convicted defendants have been sentenced to more than \$51 million in court-ordered restitutions, fines and/or forfeitures related to Medicare losses.

Both phases of the strike force have seen high levels of DME fraud, however the Miami Strike Force, operating in an area with approximately 800,000 Medicare beneficiaries, has also identified numerous cases of fraudulent activity related to infusion therapy. The Los Angeles Strike Force, with approximately 4 million beneficiaries in its scope, has identified through analysis and investigation high levels of fraud in connection with health care testing facilities as well as DME fraud.

The Los Angeles strike force teams are led by a federal prosecutor supervised by both the Criminal Division's Fraud Section in Washington, D.C., and the U.S. Attorney's Office for the Central District of California. Each team has six agents from the FBI and HHS-OIG as well as representatives from local law enforcement. The teams operate out of the U.S. Attorney's Office for the Central District of California.

The operation is being prosecuted by attorneys from the Criminal Division's Fraud Section and from the U.S. Attorney's Office for the Central District of California, and supervised by Fraud Section Assistant Chief John Kelly with support from U. S. Attorney's Office. In addition to federal agents, the teams have officers and special agents from the California Department of Justice and Bureau of Medical Fraud and Elder Abuse as well as the Los Angeles County Health Authority Law Enforcement Task Force.

An indictment is merely an allegation and defendants are presumed innocent until and unless proven guilty.

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