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(202) 514-2008  
TDD (202) 514-1888

## **STRIKE FORCE FORMED TO TARGET FRAUDULENT BILLING OF MEDICARE PROGRAM BY HEALTH CARE COMPANIES**

### ***First Eight Weeks of Strike Force Operation Nets 34 Indicted Cases Involving More Than \$142 Million in Billing***

WASHINGTON – Thirty-eight people have been arrested in the first phase of a targeted criminal, civil and administrative effort against individuals and health care companies that fraudulently bill the Medicare program, Attorney General Alberto R. Gonzales and Secretary Michael Leavitt of the U.S. Department of Health and Human Services announced today.

The arrests in the Southern District of Florida are the result of the establishment 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. Since the first phase of strike force operations began on March 1, 2007 in southern Florida, the strike force has obtained indictments of individuals and organizations that have collectively billed the Medicare program for \$142,061,059. Charges brought against the defendants in these indictments include conspiracy to defraud the Medicare program, criminal false claims, and violations of the anti-kickback statutes. If convicted, many of the defendants face up to 20 years in prison on these charges.

The strike force is able to identify potential fraud cases for investigation and prosecution quickly through real-time analysis of billing data from Medicare Program Safeguard Contractors (PSCs) and claims data extracted from the Health Care Information System. In phase one operations in Miami, teams have identified two primary schemes that defrauded the Medicare program – infusion therapy and durable medical equipment (DME) suppliers. All of the strike force cases to date target these two areas.

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 durable medical equipment and infusion areas. The Centers for Medicare and Medicaid Services (CMS) is taking steps to increase accountability and decrease the presence of fraudulent providers. The end result will be better service to beneficiaries and savings of billions of dollars that might otherwise go to fraudulent businesses.

“This initiative targets those who steal taxpayer funds intended to provide healthcare to the elderly,” stated Attorney General Gonzales. “Protecting the financial integrity of the Medicare program for generations to come is important to the millions of seniors who rely on this program. Through the collaborative efforts of federal, state and local law enforcement and other agencies, we will concentrate our efforts. The Medicare Fraud Strike Force will allow us to have real-time access to Medicare billing data and provide authority to move quickly to make arrests and bring prosecutions as quickly as possible. With better tools and information sharing, we can expect greater levels of enforcement.”

“The Medicare Fraud Strike Force is just one weapon in our arsenal to protect Medicare beneficiaries and taxpayers from fraud. I will be working closely with the Administration and Congress to put processes in place that will improve the industry and eliminate the likelihood for deception,” Secretary Leavitt said. “We will be announcing the second step in this multi-year process within the next month. We expect industry leaders will embrace the changes that will improve the quality of the durable medical equipment industry and others who serve our Medicare beneficiaries.”

On the morning of May 8, 2007, federal agents arrested 24 people to conclude a sweep in southern Florida of DME supply company owners who were engaged in various schemes to defraud Medicare based on fraudulent prescriptions. Yesterday’s arrests bring the total number of arrests to date to 38.

The indictments outline various types of fraudulent schemes. Those schemes included compounded aerosol medications -- a process where a pharmacist makes medicine to meet a special medical need for a patient, rather than dispensing less expensive commercial pharmaceuticals. The indictments allege that the homemade medications were not necessary and that they were only prescribed to defraud Medicare.

In one example, Eduardo Moreno, the owner of multiple DME companies, was arrested on April 7 after being named in a six-count indictment on fraud charges. Two of Moreno’s companies – Brenda Medical Supply Inc., and Faster Medical Equipment Inc. – allegedly billed Medicare for more than \$1.9 million for services that were not medically necessary. The FBI has seized some of Moreno’s assets, including a new Rolls Royce Phantom worth approximately \$200,000.

In a five-count indictment out of the Southern District of Florida, Barbara Diaz and Jose Prieto were charged with conspiring to defraud Medicare, submitting false claims to Medicare and money laundering. The indictment alleges that Diaz and Prieto engaged in an “infusion therapy scheme” where patients did not need the drugs that were purportedly used. From March 9 through Dec. 31, 2006, the defendants billed Medicare more than \$900,000 for infusion.

Seizure warrants have been used to take money back from bank accounts associate with the activity alleged in the indictment. In one case, HHS-Inspector General agents recovered more than \$1.2 million from a corporate bank account after arresting Leider Alexis Munoz, the president and chief executive officer of RTC of Miami, Inc., an infusion clinic located in Hialeah, Fla.

“History has shown that health care fraud is best investigated jointly. The FBI, as part of the Medicare Fraud Strike Force, worked closely with its law enforcement partners and oversight authorities to assist investigations of fraud, waste and abuse across Southern Florida,” said Assistant Director Kenneth W. Kaiser, FBI Criminal Investigative Division. “Health care fraud increases the cost of health care for everyone and the FBI remains committed to pursuing any company or individual that attempts to take advantage of the system for personal gain.”

“The landscape for fraud in south Florida has changed dramatically over the past two years. CMS has taken aggressive action to curb infusion therapy fraud and other organized fraud actions,” said Leslie Norwalk, acting administrator of the Centers for Medicare and Medicaid Services. “We have opened two satellite offices that are dedicated to combating fraud in high-risk areas and we will soon be opening a third. We are sending a strong message to those who seek to defraud the programs that if they engage in fraudulent activity, they will be caught and no longer able to take advantage of the programs to their own gain.”

The strike force teams are led by a federal prosecutor supervised by both the Criminal Division’s Fraud Section in Washington and the office of U.S. Attorney R. Alexander Acosta of the Southern District of Florida. Each team has four to six agents, at least one agent from the FBI and HHS Office of Inspector General, as well as representatives of local law enforcement. The teams operate out of the federal Health Care Fraud Facility in Miramar, Fla.

The operation is being prosecuted by attorneys from the Criminal Division’s Fraud Section and the Major Crimes Section of the U.S. Attorney’s Office for the Southern District of Florida, and supervised by Fraud Section Deputy Chief Kirk Ogrosky and Chief of the Criminal Division in Miami, Matthew Menchel. In addition to federal agents, the teams have officers and detectives from the Florida Medicaid Fraud Control Unit and Hialeah Police Department.

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

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