UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

UNITED STATES OF AMERICA

v.

FARID FATA, M.D.,

Defendant.

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CRIMINAL NO.: 13-CR-20600

HONORABLE PAUL D. BORMAN

VIOL: 18 U.S.C. § 1347
18 U.S.C. § 371
18 U.S.C. § 1425(a)
18 U.S.C. § 982

FILED
2013 SEP 18 P 4: 25
U.S. DIST. COURT CLERK
EAST. DIST. MICHIGAN
DETROIT

FIRST SUPERSEDING INDICTMENT

THE GRAND JURY CHARGES:

General Allegations

At all times relevant to this Indictment:

1. The Medicare program was a federal health care program providing benefits to persons who were over the age of 65 or disabled. Medicare was administered by the Centers for Medicare and Medicaid Services (CMS), a federal agency under the United State Department of Health and Human Services. Individuals who received benefits under Medicare were referred to as Medicare "beneficiaries."

2. Medicare was a "health care benefit program," as defined by 18 U.S.C. § 24(b).

3. The Medicare Program included coverage under two primary components—hospital insurance (Part A) and medical insurance (Part B). Part B of the Medicare Program covered the costs of physicians' services and other ancillary services (including testing) not covered by Part A. The claims at issue in this indictment were submitted under Part B of the Medicare Program.

4. Wisconsin Physicians Service was the CMS contracted carrier for Medicare Part B in the state of Michigan. TrustSolutions LLC was the Program Safeguard Contractor for Medicare Part B in the State of Michigan until April 24, 2012, when it was replaced by Cahaba Safeguard Administrators LLC.

5. By becoming a participating provider in Medicare, enrolled providers agreed to abide by the policies and procedures, rules, and regulations governing reimbursement. In order to receive Medicare funds, enrolled providers, together with their authorized agents, employees, and contractors, were required to abide by all the provisions of the Social Security Act, the regulations promulgated under the Act, and applicable policies and procedures, rules, and regulations, issued by CMS and its authorized agents and contractors.

6. Upon certification, the medical provider, whether a clinic or an individual, was assigned a provider identification number for billing purposes (referred to as a

PIN). When the medical provider rendered a service, the provider would submit a claim for reimbursement to the Medicare contractor/carrier that included the PIN assigned to that medical provider. When an individual medical provider was associated with a clinic, Medicare Part B required that the individual provider number associated with the clinic be placed on the claim submitted to the Medicare contractor.

7. Health care providers were given and provided with online access to Medicare manuals and services bulletins describing proper billing procedures and billing rules and regulations. Providers could only submit claims to Medicare for medically necessary services they rendered, and providers were required to maintain patient records to verify that the services were provided as described on the claim.

8. To receive reimbursement for a covered service from Medicare, a provider was required to submit a claim, either electronically or using a form (e.g., a Form CMS-1500 or UB-04), containing the required information appropriately identifying the provider, beneficiary, and services rendered, among other things.

9. Blue Cross and Blue Shield of Michigan (BCBSM) was a non-profit, privately operated insurance company authorized and licensed to do business in the state of Michigan.

10. BCBSM was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b).

11. BCBSM had agreements with participating providers to furnish medical services to patients ensured by BCBSM. The agreements allowed the participating providers to bill BCBSM directly, and to be paid directly, for services provided to insured patients. BCBSM routinely issued notices to all participating providers advising them services not reasonably necessary for patient treatment would not be paid by BCBSM.

12. BCBSM required participating providers to provide a diagnostic code and a procedure code on claims in order to be paid for professional services rendered to BCBSM subscribers. Payment for services depended upon the truthful submission of specific diagnostic and procedure codes indicated on the claim. BCBSM distributed payments to participating providers electronically, by depositing money into the providers' bank account of record, or by mailing a check to the provider's address of record.

13. Health Alliance Plan of Michigan (HAP) was a non-profit health maintenance organization authorized and licensed to do business in the state of Michigan.

14. HAP was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b).

15. HAP had agreements with participating providers to furnish medical services to patients who were enrolled as members. HAP's agreements with participating providers required that providers bill HAP only for covered services, which included only those that were medically necessary.

16. HAP required participating providers to provide a diagnostic code and a procedure code on claims in order to be paid for professional services rendered to HAP subscribers. Payment for services depended upon the truthful submission of specific diagnostic and procedure codes indicated on the claim. HAP distributed payments to participating providers electronically, by depositing money into the providers' bank account of record, or by mailing a check to the provider's address of record.

17. Aetna Life Insurance Company (Aetna) was an insurance company authorized and licensed to do business in the state of Michigan.

18. Aetna issued a "health care benefit program," as defined by Title 18, United States Code, Section 24(b).

19. Aetna had agreements with participating providers to furnish medical services to patients who were enrolled as members. Aetna's agreements with participating providers required that the provider acknowledge that they will not be paid for services that are not covered by the plan. Services that are not medically necessary are not covered by the plan.

20. Aetna required participating providers to provide a diagnostic code and a procedure code on claims in order to be paid for professional services rendered to Aetna subscribers. Payment for services depended upon the truthful submission of specific diagnostic and procedure codes indicated on the claim. Aetna distributed payments to participating providers electronically, by depositing money into the providers' bank account of record, or by mailing a check to the provider's address of record.

21. Michigan Hematology Oncology, P.C. (MHO) was a Michigan corporation, incorporated in or around April 2005, doing business at various locations in the Eastern District of Michigan, including 1901 Star Batt Drive, Suite 200, Rochester Hills, Michigan; 5680 Bow Pointe Drive, Suite 201, Clarkston, Michigan; 2520 S. Telegraph Road, Suite 107, Bloomfield Hills, Michigan; 944 Baldwin Road, Suite G, Lapeer, Michigan; 37450 Dequindre Road, Sterling Heights, Michigan; 2891 E. Maple, Suite 102, Troy, Michigan; and 15300 W. 9 Mile Road, Oak Park, Michigan. MHO was enrolled as a participating provider with Medicare, BCBSM, HAP and Aetna.

22. Defendant FARID FATA, M.D., a resident of Oakland County, Michigan, was a Medical Doctor licensed in the State of Michigan. FARID FATA, M.D., owned and operated MHO. FARID FATA, M.D., was enrolled as a participating provider with Medicare, BCBSM, HAP and Aetna.

COUNTS 1-12
(18 U.S.C. § 1347– Health Care Fraud)

23. Paragraphs 1 through 22 of the General Allegations section of this Indictment are realleged and incorporated by reference as though fully set forth herein.

24. From in or around August 2007, and continuing through in or around August 2013, the exact dates being unknown to the Grand Jury, in Oakland County, in the Eastern District of Michigan, and elsewhere, the defendant, FARID FATA, M.D., in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud a health care benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), that is Medicare, BCBSM, HAP and Aetna, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by and under the custody and control of Medicare, BCBSM, HAP, and Aetna in connection with the delivery of and payment for health care benefits, items, and services.

Purpose of the Scheme and Artifice

25. It was a purpose of the scheme and artifice for FARID FATA, M.D., to unlawfully enrich himself through the submission of false and fraudulent

Medicare, BCBSM, HAP, and Aetna claims for services that were not medically necessary.

The Scheme and Artifice

26. FARID FATA, M.D., would submit or cause the submission of false and fraudulent claims to Medicare, BCBSM, HAP, and Aetna for services that were not medically necessary, including claims for (a) administering chemotherapy and other cancer treatments to patients whose medical conditions did not support the treatments; (b) administering intravenous immunoglobulin therapy to patients whose medical conditions did not support the therapy; and (c) administering intravenous iron treatments to patients who were not iron deficient.

27. From in or around August 2007, through in or around August 2013, FARID FATA, M.D., submitted and caused MHO to submit approximately $225 million in claims to Medicare, of which approximately $109 million was for chemotherapy or other cancer treatment drugs. Of the approximate $225 million, Medicare paid over $91 million, of which over $48 million was for chemotherapy or other cancer treatment drugs.

28. FARID FATA, M.D. submitted and caused MHO to submit claims for years of medically unnecessary treatments including the following repeated and unnecessary chemotherapy and cancer drug treatments for individuals who did not, in fact, have cancer including the following: approximately 155 chemotherapy

treatments for patient W.W. between on or about January 3, 2011 and or about July 1, 2013; approximately 21 chemotherapy treatments for patient W.D. between on or about May 20, 2013, and on or about July 23, 2013; approximately 25 cancer drug treatments for patient R.S. between on or about August 5, 2011 and on or about July 25, 2013; and approximately 28 chemotherapy treatments for patient J.M. between on or about December 18, 2012 and on or about May 21, 2013.

Acts in Execution of the Scheme and Artifice

29. In execution of the scheme and artifice, FARID FATA, M.D. caused the submission of the following claims to Medicare, BCBSM, HAP and Aetna for services that were not medically necessary:

Count	Patient	Insurer	On or About Service Date	Description of Item Billed	Approximate Amount Billed
1	W.D.	Medicare	5/23/13	Azacitidine (chemotherapy)	$700
2	W.D.	Medicare	7/18/13	Azacitidine (chemotherapy)	$700
3	W.V.	Medicare	5/23/12	Ferumoxytol (iron)	$1020
4	W.V.	Medicare	5/29/12	Ferumoxytol (iron)	$1020
5	W.V.	Medicare	5/20/13	Ferumoxytol (iron)	$1020
6	R.S.	BCBSM	10/6/11	Zoledronic Acid (cancer drug)	$1120
7	R.S.	Medicare	11/15/12	Zoledronic Acid (cancer drug)	$1120

8	M.F.	HAP	7/1/13	Bortezomib (chemotherapy)	$2100
9	J.M.	Medicare	12/21/12	Bortezomib (chemotherapy)	$2100
10	J.M.	Medicare	4/26/13	Bortezomib (chemotherapy)	$2100
11	W.W.	Aetna	2/8/13	Decitabine (chemotherapy)	$3750
12	W.W.	Aetna	3/8/13	Decitabine (chemotherapy)	$3750

In violation of Title 18, United States Code, Section 1347.

COUNT 13
(18 U.S.C. § 371 – Conspiracy to Pay and Receive Kickbacks)

30. Paragraphs 1 through 22 of the General Allegations section of this Superseding Indictment are realleged and incorporated by reference as though fully set forth herein.

31. From in or around October 2010 and continuing through in or around August 2013, the exact dates being unknown to the Grand Jury, in Oakland County, in the Eastern District of Michigan, and elsewhere, the defendant FARID FATA, M.D. did willfully and knowingly combine, conspire, confederate and agree with others, known and unknown to the Grand Jury, to commit certain offenses against the United States, that is,

(a) to violate Title 42, United States Code, Section 1320a-7b(b)(2)(A) by knowingly and willfully offering and paying any remuneration

(including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part by Medicare, a federal health care program as defined in Title 18, United States Code, Section 24(b); and

(b) to violate Title 42, United States Code, Section 1320a-7b(b)(1)(A) by knowingly and willfully soliciting and receiving any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part by Medicare, a federal health care program as defined in Title 18, United States Code, Section 24(b).

Purpose of the Conspiracy

32. It was a purpose of the conspiracy for defendant FARID FATA, M.D. to unlawfully enrich himself through the solicitation and receipt of kickbacks in exchange for the referral of services and arranging for the furnishing of services, including home health care services and hospice services.

Manner and Means

33. The manner and means by which the defendant sought to accomplish the purpose of the conspiracy included, among other things:

34. FARID FATA, M.D. would solicit kickback payments from providers of home health care and hospice services.

35. In exchange for such kickbacks, FARID FATA, M.D. would refer patients for home health care services and hospice services purportedly provided by these providers, who were reimbursed in whole or in part by Medicare.

Overt Acts

36. In furtherance of the conspiracy, and to accomplish its purposes and objects, at least one of the conspirators committed, or caused to be committed, in the Eastern District of Michigan, the following overt acts, among others:

37. On or about October 1, 2010, defendant FARID FATA, M.D. received a check in the amount of $1,000 from Guardian Angel Home Care, Inc. with the memo line "Medical Director Hospice."

38. On or about January 1, 2011, defendant FARID FATA, M.D. received a check in the amount of $1,000 from Guardian Angel Home Care, Inc. with the memo line "Medical Director Hospice."

39. On or about May 1, 2011, defendant FARID FATA, M.D. received a check in the amount of $1,000 from Guardian Angel Home Care, Inc. with the memo line "Medical Director Hospice."

All in violation of Title 18, United States Code, Section 371.

COUNT 14
(Unlawful Procurement of Naturalization – 18 U.S.C. § 1425(a))

40. Paragraphs 1 through 22 of the General Allegations section of this Indictment are realleged and incorporated by reference as though fully set forth herein.

41. On or about March 10, 2008, FARID FATA, M.D. completed a naturalization application to become a United States citizen (Form N-400). Question 15 of Section D stated: "Have you ever committed a crime or offense for which you were not arrested?" FARID FATA, M.D. falsely checked the box for the answer "No." In fact, as FARID FATA, M.D. then well knew, he had as of that date committed crimes of health care fraud.

42. On or about September 22, 2008, a United States Customs and Immigration Services officer interviewed FARID FATA, M.D. regarding his naturalization application. Under oath, FATA repeated his false answer to question 15 of Part D, again stating that he had never knowingly committed a criminal offense for which he had not been arrested.

43. On or about March 28, 2009, FATA completed a Form N-445, entitled "Notice of Naturalization Oath Ceremony." Question 3 of that form stated:

"AFTER the date you were first interviewed on your Application for Naturalization, Form N-400: . . . Have you knowingly committed any crime or offense, for which you have not been arrested?" FATA checked the box for the answer "No" and signed the Form N-445, falsely certifying that he had committed no crime between the date of his interview with Citizenship and Immigration Services (September 22, 2008) and the date he completed the Form N-445 (March 28, 2009).

44. On or about April 2, 2009, FARID FATA, M.D. was sworn in as a United States citizen in an oath ceremony conducted by the United States District Court, Eastern District of Michigan.

45. On or about April 2, 2009, in the Eastern District of Michigan, FARID FATA, M.D., defendant herein, knowingly procured his naturalization as a United States citizen contrary to law. Defendant FARID FATA, M.D. obtained his citizenship despite having committed numerous criminal offenses, by knowingly making a false statement on his Form N-400, by knowingly making a false statement to an immigration officer, and by knowingly making a false statement on his Form N-445, each of which related to his criminal history and his Good Moral Character, and each of which omitted the fraud offenses which he had committed. All in violation of Title 18, United States Code, Section 1425(a).

CRIMINAL FORFEITURE
(18 U.S.C. § 982)

46. The above allegations contained in this Indictment are incorporated by reference as if set forth fully herein for the purpose of alleging forfeiture pursuant to the provisions of 18 U.S.C. § 982.

47. As a result of the violations of 18 U.S.C. § 1347, as set forth in this Indictment, FARID FATA, M.D., shall forfeit to the United States any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of such violations, pursuant to 18 U.S.C. § 982(a)(7).

48. Substitute Assets: If the property described above as being subject to forfeiture, as a result of any act or omission of the defendant:

a. cannot be located upon the exercise of due diligence;

b. has been transferred or sold to, or deposited with, a third party;

c. has been placed beyond the jurisdiction of the Court;

d. has been substantially diminished in value; or

e. has been commingled with other property that cannot be subdivided without difficulty;

it is the intent of the United States, pursuant to 21 U.S.C. § 853(p) as incorporated by 18 U.S.C. § 982(b), to seek to forfeit any other property of the defendant up to the value of the forfeitable property described above.

49. Money Judgment: A sum of money in United States currency in the amount representing the total amount of proceeds obtained as a result of defendant's violations, as alleged in this Indictment.

THIS IS A TRUE BILL.

s/ GRAND JURY FOREPERSON
GRAND JURY FOREPERSON

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Dated: September 18, 2013