STATE OF WISCONSIN CIRCUIT COURT MILWAUKEE COUNTY

STATE OF WISCONSIN ,

Plaintiff,

v. Case No. 21-CF-

FARID A. AHMAD
8911 S RIDGE CROFT DR
OAK CREEK, WI 53154
DOB: 10/28/1968,

Defendant.

CRIMINAL COMPLAINT

The Wisconsin Department of Justice, pursuant to its jurisdiction under Wis. Stat. § 49.846(2), files this complaint against Farid A. Ahmad (DOB: 10/28/1968).

The State of Wisconsin alleges that Ahmad, a medical doctor, engaged in two different courses of criminal conduct while he was a Medicaid provider. First, he used a nurse's National Provider Identifier (NPI) beyond her original consent, to prescribe medication to his patients after he lost his Medicaid provider certification. Second, he overbilled Medicaid by: (1) using inaccurate medical codes to inflate his rate of payment and (2) billing for unnecessary in-home examinations.

Count 1: UNAUTHORIZED USE OF AN INDIVIDUAL'S PERSONAL IDENTIFYING INFORMATION

On or between September 1, 2018, and September 30, 2018, in the City of Oak Creek, Milwaukee County, Wisconsin, the defendant, Farid A. Ahmad, intentionally

used, attempted to use, or possessed with intent to use, the personal identifying information or personal identification document of an individual without the authorization or consent of the individual and by representing that he was the individual, or that he was acting with the authorization or consent of the individual, to obtain credit, money, goods, services, employment, or any other thing of value or benefit, contrary to Wis. Stat. §§ 943.201(2)(a) and 939.50(3)(h).

Upon conviction for this offense, a Class H Felony, the defendant may be fined not more than $10,000, or imprisoned not to exceed six years, or both.

Count 2: MEDICAL ASSISTANCE FRAUD

On or about September 6, 2018, in the City of Oak Creek, Milwaukee County, Wisconsin, the defendant, Farid A. Ahmad, made or caused to be made a false statement or representation of material fact in an application for a Medical Assistance benefit or payment, contrary to Wis. Stat. §§ 946.91(2)(a) and 939.50(3)(h). To wit: he made or caused to be made a false representation of material fact—that a certified Medicaid provider had authorized the prescription—in an application for a Medical Assistance benefit.

Upon conviction for this offense, a Class H Felony, the defendant may be fined not more than $25,000, or imprisoned not more than six years, or both.

Count 3: FELONY THEFT BY FRAUD

On or between February 20, 2015, and September 8, 2018, in the City of Oak Creek, Milwaukee County, Wisconsin, the defendant, Farid A. Ahmad, did obtain title to property of another person by intentionally deceiving the person with a false

representation which was known to be false, made with intent to defraud, which did defraud the person to whom it was made, and the value of the property taken exceeds $10,000 but does not exceed $100,000, contrary to Wis. Stat. §§ 943.20(1)(d); 943.20(3)(c); and 939.50(3)(g).

Upon conviction for this offense, a Class G Felony, the defendant may be fined not more than $25,000, or imprisoned not more than ten years, or both.

Count 4: MEDICAL ASSISTANCE FRAUD

On or about November 5, 2015, in the City of Oak Creek, Milwaukee County, Wisconsin, the defendant, Farid A. Ahmad, made or caused to be made a false statement or representation of material fact in an application for a Medical Assistance benefit or payment, contrary to Wis. Stat. §§ 946.91(2)(a) and 939.50(3)(h).

Upon conviction for this offense, a Class H Felony, the defendant may be fined not more than $25,000, or imprisoned not more than six years, or both.

Count 5: MEDICAL ASSISTANCE FRAUD

On or about April 24, 2018, in the City of Oak Creek, Milwaukee County, Wisconsin, the defendant, Farid A. Ahmad, made or caused to be made a false statement or representation of material fact in an application for a Medical Assistance benefit or payment, contrary to Wis. Stat. §§ 946.91(2)(a) and 939.50(3)(h).

Upon conviction for this offense, a Class H Felony, the defendant may be fined not more than $25,000, or imprisoned not more than six years, or both.

Facts Constituting the Offenses Charged

Fraud Investigator Brittany Ben-Zikri, with the Medicaid Fraud Control and Elder Abuse Unit at the Wisconsin Department of Justice, being first duly sworn, states that:

I, the Complainant, am a Fraud Investigator with the Wisconsin Department of Justice's Medicaid Fraud Control and Elder Abuse Unit (MFCEAU). MFCEAU investigates and prosecutes civil and criminal offenses related to Medicaid. Accordingly, I conduct investigations and audits of Medicaid-funded programs and providers, including physicians.

I base this complaint upon my investigation, my training and experience, my review of business records, and my interviews with witnesses. I have, moreover, found business records to be reliable in the past. I believe the witness statements are truthful.

This complaint contains a summary of facts necessary to establish probable cause; it does not contain all facts related to this investigation.

Based upon information and belief, I state:

Background

The Wisconsin Medical Assistance program, commonly referred to as Medicaid, is a joint federal and state program that provides coverage for numerous health services to Wisconsin residents. Medicaid has various rules governing eligibility for both providers and beneficiaries. For instance, to participate in the Medicaid program

as a provider, medical professionals must be certified by the Department of Health Services (DHS). Wis. Admin. Code § DHS 106.02(1) (Jan. 2014).

Farid A. Ahmad is a medical doctor, and he received a certification to be a Medicaid provider from DHS in 2014. He provided health services through his company, Mobile Medical Clinic, Inc. (Mobile Medical). Mobile Medical is a mobile healthcare provider that conducts health related examinations at patients' residences. Ahmad was the owner, registered agent, managing employee, and sole physician of Mobile Medical. Thus, he was responsible for Mobile Medical's day-to-day operations and billing practices. Mobile Medical's principal office was in the City of Oak Creek, Milwaukee County, Wisconsin.

Counts 1 and 2:

As noted above, Ahmad became a certified Medicaid provider in 2014. However, on July 30, 2018, DHS suspended Ahmad's certification, barring him from receiving reimbursement from Medicaid for services provided after that date. Medicaid would have also refused any claims for reimbursement for prescriptions written by Ahmad following the suspension of his certification.

To simplify billing and the transmission of health information, all healthcare providers are assigned a unique, ten-digit numeric identifier called a National Provider Identifier Standard (NPI). Providers must use their NPI in administrative and financial transactions under the Health Insurance Portability and Accountability Act. After his suspension, Ahmad wrote hundreds of prescriptions for his patients using the NPI of Victim A, an advanced practice nurse prescriber.

I interviewed Victim A twice. Victim A said she worked with Ahmad at Mobile Medical in 2014 or 2015. At that time, Ahmad had Victim A's NPI so he could bill Medicaid for services she had rendered for Mobile Medical's patients. Victim A last worked for Ahmad in 2015.

In or around September 2018, Victim A said Ahmad asked her to approve a refill for a prescription of blood pressure medication for one of his patients. Victim A agreed. In September 2018, Ahmad submitted 299 prescriptions to Omni Pharmacy under Victim A's NPI and name for his patients who were Medicaid beneficiaries. Victim A—except for the one previously mentioned patient—did not authorize any of the prescriptions.

Furthermore, from September 1, 2018, through September 8, 2018, Ahmad submitted at least eight prescriptions for controlled substances using Victim A's name and NPI. Victim A confirmed that she did not meet with any of these patients and did not authorize any of these prescriptions. For example, one of the prescriptions for was for sixty pills of Hydrocodone-Acetaminophen, a schedule II controlled substance. Wis. Stat. § 961.16(2)(a)7. The paper prescription identifies Ahmad as the prescriber. Ahmad's name is crossed out on the prescription, and Victim A's name is handwritten in its place. Ahmad's NPI was also identified on the prescription and crossed out, and Victim A's NPI was handwritten in its place. Ahmad wrote the prescription on September 6, 2018.

Ahmad electronically submitted the prescriptions to Omni Pharmacy. Omni Pharmacy is located in the City of Milwaukee, Milwaukee County, Wisconsin.

On November 26, 2019, I interviewed Ahmad at his home. I was accompanied by Special Agent Ken Folkers of the Division of Criminal Investigation. During the interview, Ahmad stated that Victim A agreed to approve his routine, non-narcotic medication refills. Furthermore, Ahmad stated he only prescribed routine medications, no controlled substances, under Victim A's NPI. Ahmad believed Omni Pharmacy submitted the prescription claim listing Victim A as the prescriber without contacting him first.

Counts 3 through 5:

Provider claims for payment from Medicaid must meet various requirements. For one, all claims must be for services which are "appropriate and medically necessary." Wis. Admin. Code § DHS 106.02(5) (Jan. 2014). "Medically necessary" services are required to treat the patient, are appropriate in regard to generally accepted standards of medical practice, and are not solely for the convenience of the patient or provider. Wis. Admin. Code § DHS 101.03(96m)(a), (b)3, (b)7 (May 2019). Provider claims must also be accurate and truthful. Wis. Admin. Code § DHS 106.03(2)(c) (Jan. 2014). All claims, moreover, must be submitted in accordance with "coding information" provided by DHS. Wis. Admin. Code § DHS 106.03(2)(b) (Jan. 2014).

Regarding "coding information," to facilitate uniform and efficient billing and documentation, medical services, which often defy concise linguistic description, are instead assigned a five-digit numeric code. These codes are part of the Current Procedural Terminology (CPT) code set. So, in practice, the obligation that all claims

be accurate and truthful requires providers to use the appropriate CPT code to describe the actual service provided. And because each CPT code describes a different medical service, the rates of payment between codes also differ. If a provider intentionally uses inaccurate codes to fraudulently inflate his payment from Medicaid, that is called "upcoding."

My investigation revealed that Ahmad defrauded Medicaid by "upcoding" and by seeking payment for services which were not "medically necessary."

Upcoding:

While there are numerous CPT codes describing the full range of medical services, there are only four codes which concern home visits for established patients. *See* Am. Med. Ass'n, *CPT 2018* 31 (2017). Those codes are: 99347, 99348, 99349, and 99350. *Id.* CPT codes 99347[1] and 99348[2] describe medical services which are less

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[1] CPT code 99347 deals with home visits for the evaluation and management of an established patient, which require at least 2 of these 3 key components: (1) a problem focused interval history, (2) a problem focused examination, and (3) straightforward medical decision making.

Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family. *See* Am. Med. Ass'n, *CPT 2018* 31 (2017).

[2] CPT code 99348 concerns home visits for the evaluation and management of an established patient, which require at least 2 of these 3 key components: (1) an expanded problem focused interval history, (2) an expanded problem focused examination, and (3) medical decision making of low complexity.

Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family. *See* Am. Med. Ass'n, *CPT 2018* 31 (2017).

complicated, and CPT codes 99349[3] and 99350[4] describe medical services which are moderately or highly complex. *Id.*

Ahmad regularly submitted claims for reimbursement using CPT codes 99349 and 99350. These codes describe comprehensive, in-home medical examinations which typically take forty minutes or one hour, respectively, to complete. *Id.* Yet my interviews with Ahmad's patients revealed that his examinations regularly lasted twenty-five minutes or less, which indicates that he did not truly provide comprehensive examinations. For instance:

- Patient A said that Ahmad's home visits typically lasted fifteen to twenty minutes. Billing records indicate that Patient A saw Ahmad eighteen times between August 29, 2015, and October 16, 2017. Across those eighteen home visits, Ahmad used CPT code 99349 ten times and code 99350 seven times.

- Patient B said that every home visit with Ahmad lasted approximately ten minutes, never longer. Billing records indicate that Patient B saw Ahmad thirty-two times between March 7, 2015, and April 12, 2018. Over those thirty-two visits, Ahmad used CPT code 99349 twenty-two times and code 99350 six times.

- Patient C said that Ahmad's home visits lasted approximately fifteen minutes. Patient C saw Ahmad twenty-eight times from February 14, 2015,

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[3] CPT code 99349 relates to a home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: (1) a detailed interval history, (2) a detailed examination, and (3) medical decision making of moderate complexity.

Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family. *See* Am. Med. Ass'n, *CPT 2018* 31 (2017).

[4] CPT code 99350 concerns a home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: (1) a comprehensive interval history, (2) a comprehensive examination, and (3) medical decision making of moderate to high complexity.

Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family. *See* Am. Med. Ass'n, *CPT 2018* 31 (2017).

through July 21, 2018, according to billing records. Ahmad used CPT code 99349 twenty times and code 99350 four times.

- Patient D said Ahmad's visits typically lasted about twenty-five minutes. Patient D saw Ahmad twenty-eight times from February 11, 2016, until June 30, 2018. Ahmad used CPT code 99349 fourteen times and code 99350 twelve times.

- Patient E said Ahmad's examinations typically lasted five to ten minutes. Patient E saw Ahmad five times between May 14, 2015, and June 15, 2016. Ahmad used CPT code 99349 on four occasions and code 99350 once.

- Patient F said that Ahmad's home visits typically lasted between fifteen and twenty minutes. Patient F saw Ahmad thirty-four times between February 25, 2015, and July 11, 2018. Following those visits, Ahmad sought reimbursement using CPT code 99349 seventeen times and code 99350 fourteen times.

In contrast to his use of CPT codes 99349 and 99350, Ahmad seldom billed under CPT codes 99347 and 99348. Codes 99347 and 99348 describe examinations which are more limited in scope and, accordingly, describe shorter home visits of about fifteen or twenty-five minutes, respectively. *Id.* Of the 145 home visits that Ahmad conducted for Patients A through F, Ahmad only used CPT codes 99347 and 99348 a total of eleven times, which is less than eight percent of the time. On the other hand, Ahmad used CPT codes 99349 and 99350 a total of 131 times, which is over ninety percent of the time.

Given that different codes describe different medical services—and, therefore, have different rates of reimbursement—this disparity in Ahmad's code usage led to an inflated rate of payment from Medicaid. The reimbursement rates for these codes can vary by a few dollars if the Medicaid recipient is responsible for any costs, but, at

the high end, CPT code 99347 is reimbursed at $40.01, 99348 is reimbursed at $63.50, 99349 is reimbursed at $98.45, and 99350 is reimbursed at $145.48.

On November 26, 2019, I, along with Special Agent Ken Folkers from the Division of Criminal Investigation, interviewed Ahmad. Ahmad said that he scheduled between ten and twenty patient appointments each day. Ahmad said that the average visit lasted ten to fifteen minutes, rarely more than thirty minutes unless he was meeting with a new patient, which could take up to an hour. Ahmad said that he could bill for the full hour even if the appointment lasted less than an hour. Ahmad said that the face-to-face encounter with the patient may only take fifteen minutes, but he spent additional time traveling to and from the patient's home, documenting the encounter, and submitting any additional referrals to other providers. Thus, according to Ahmad, it is appropriate to bill for the entire time relating to the patient visit, including travel time and time spent completing paperwork or submitting forms.[5] Ahmad further explained that a visit with a patient with more than three chronic conditions was automatically an advanced-level visit due to the complexity.[6] Ahmad also mentioned that Medicaid reimbursements were unfairly low.

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[5] According to the American Medical Association, the face-to-face time associated with medical services is "a valid proxy for the total work done before, during, and after the visit." Am. Med. Ass'n, *CPT 2018* 8 (2017). The time element is included as an explicit factor, moreover, to assist in selecting the most appropriate level of service. *Id.* at 7.

[6] The complexity of medical decision making is a factor in determining the level of service. *See* Am. Med. Ass'n, *CPT 2018* 6 (2017). But underlying diseases, in and of themselves, are not considered in selecting the level of service "*unless* their presence significantly increases the complexity of the medical decision making." *Id.* at 10.

"Medically Necessary"

As noted above, "medically necessary" means, in part, that the medical service is "not solely for the convenience of the recipient, the recipient's family or a provider." Wis. Admin. Code § DHS 101.03(96m)(b)7 (May 2019). Moreover, "[i]t is not medically necessary or appropriate to bill a higher level of E&M [evaluation and management] service when a lower level of service is warranted."[7] The CPT codes that Ahmad used are defined, in part, by the fact that the medical service occurs in the patient's home. My interviews with Ahmad's patients, however, uncovered Ahmad's practice of billing for examinations that did not need to take place in the patient's home. More specifically:

- Patient A said that Ahmad offered to conduct home visits rather than have Patient A travel to his office for medical appointments. Patient A said that she can leave her home and does so regularly for other appointments.

- Patient B said that all his appointments with Ahmad were in-home. Patient B said that he did not like Ahmad coming to his home and would have preferred to go to a doctor's office. During the time that Patient B received care from Ahmad, Patient B left his home for appointments with other professionals.

- Patient C said that he routinely left his home for other appointments during the time that Ahmad provided medical care. Patient C said that he preferred to have Ahmad come to his home but was not unable to leave his home for other medical care.

- Patient D said that he can leave his home but struggles to arrange transportation at times.

- Patient E said that she left her home to attend physical therapy and various other professional appointments during the time that Ahmad provided medical care.

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[7]DHS, *Topic #19797*, https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=50&s=2&c=61&nt=Medical+Necessity&adv=Y (last visited Apr. 28, 2021) (ForwardHealth Provider Handbook for BadgerCare Plus and Medicaid).

- Patient F said she regularly leaves her home to attend appointments with other medical professionals.

During his interview, Ahmad said that his practice of home visits was created to improve medical access to patients in underserved communities who lack reliable transportation and/or a support network to assist them in going to a clinic during normal business hours. Ahmad said most of his patients were disabled, either physically or mentally, which made getting to and from clinic appointments even more difficult.

Concerning Count 3, billing records show that Ahmad submitted his reimbursement requests for the above-mentioned patients to DHS between February 20, 2015, and September 8, 2018. Ahmad received a total of $15,501.65 from Medicaid for these home visits.

As for Count 4, billing records show that Ahmad submitted a reimbursement request on November 5, 2015, for a home visit with Patient A that took place on September 19, 2015. Ahmad used CPT code 99349 and was paid $95.45. As noted above, Patient A said that visits with Ahmad typically lasted fifteen to twenty minutes. In addition, Ahmad's code submissions indicate that he provided about 31.5 hours of medical services on September 19, 2015.

Regarding Count 5, billing records show that Ahmad submitted a reimbursement request on April 24, 2018, for a home visit with Patient B that took place on April 12, 2018. Ahmad used CPT code 99349 and was paid $95.45. As

previously stated, Patient B said that visits with Ahmad lasted approximately ten minutes.

Dated this 6th day of May, 2021.

Brittany Ben-Zikri
Fraud Investigator
Medicaid Fraud Control and Elder Abuse Unit
Wisconsin Department of Justice

Subscribed and sworn to
before me and approved for filing
this 6th day of May, 2021.

TIMOTHY J. FILIPA
NOTARY PUBLIC
STATE OF WISCONSIN

TIMOTHY J. FILIPA
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