# PRESS RELEASE

Internal Revenue Service - Criminal Investigation
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Date: November 11, 2016

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IRS – Criminal Investigation

CI Release #: CI-2016-11-11-A

## Jury Convicts Home Health Agency Owner in $13 Million Medicare Fraud Conspiracy

A federal jury in the Southern District of Texas convicted a Houston-based home-health agency owner for her role in a $13 million Medicare fraud scheme and money laundering.

Assistant Attorney General Leslie R. Caldwell of the Justice Department's Criminal Division, U.S. Attorney Kenneth Magidson of the Southern District of Texas, Special Agent in Charge D. Richard Goss of Internal Revenue Service-Criminal Investigation's (IRS-CI) Houston Field Office, Special Agent in Charge Perrye K. Turner of the FBI's Houston Field Office and Special Agent in Charge C.J. Porter of the Department of Health and Human Services Office of the Inspector General's (HHS-OIG) Dallas Regional Office made the announcement.

Marie Neba, 52, of Sugarland, Texas, co-owner of Fiango Home Healthcare Inc. (Fiango) was convicted yesterday of one count of conspiracy to commit health care fraud, three counts of health care fraud, one count of conspiracy to pay and receive health care kickbacks, one count of payment and receipt of health care kickbacks, one count of conspiracy to launder monetary instruments and one count of making false statements. A week into the trial, her co-owner and husband, Ebong Tilong, 52, also of Sugarland, pleaded guilty to one count of conspiracy to commit health care fraud, three counts of healthcare fraud, one count of conspiracy to pay and receive healthcare kickbacks, three counts of payment and receipt of healthcare kickbacks and one count of conspiracy to launder monetary instruments. Neba and Tilong are scheduled to be sentenced on Feb. 17, 2017.

According to the evidence presented at trial and admissions made in connection with Tilong's plea, from February 2006 through June 2015, Neba, Tilong and others conspired to defraud Medicare by submitting over $13 million in false and fraudulent claims for home-health services to Medicare through Fiango. Neba and Tilong paid illegal kickbacks to physicians in exchange for authorizing medically unnecessary home-health services for Medicare beneficiaries. Using the money that Medicare paid for such fraudulent claims, Neba and Tilong paid illegal kickbacks to patient recruiters for referring Medicare beneficiaries for home-health services. Neba and Tilong also paid illegal kickbacks to Medicare beneficiaries for allowing them to bill Medicare using their Medicare information for home-health services that were not medically necessary or not provided. Neba and Tilong falsified medical records to make it appear as though the Medicare beneficiaries qualified for and received home-health services.

According to the evidence presented at trial and Tilong's admissions, from February 2006 to June 2015, Neba and Tilong received more than $13 million from Medicare for home-health services that were not medically necessary or not provided to Medicare beneficiaries.

To date, three others have pleaded guilty in connection with the scheme: Nirmal Mazumdar, M.D., the former medical director of Fiango, pleaded guilty to a scheme to commit health care fraud; and Daisy Carter and Connie Ray Island, two patient recruiters for Fiango, pleaded guilty to conspiracy to commit health care fraud. Mazumdar, Carter and Island all await sentencing.

The IRS-CI, FBI and HHS-OIG investigated the case under the supervision of the Criminal Division's Fraud Section and the U.S. Attorney's Office of the Southern District of Texas. Trial Attorney William S.W. Chang and Senior Trial Attorney Jonathan T. Baum of the Fraud Section are prosecuting the case.

The Criminal Division's Fraud Section leads the Medicare Fraud Strike Force. Since its inception in March 2007, the Medicare Fraud Strike Force, now operating in nine cities across the country, has charged more than 2,900 defendants who have collectively billed the Medicare program for more than $10 billion. In addition, HHS's Centers for Medicare & Medicaid Services, working in conjunction with HHS-OIG, is taking steps to increase accountability and decrease the presence of fraudulent providers.

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