SUBMISSION — TRANCHE 2

CONSOLIDATED REPORT

DOGE Medicaid Provider Spending Dataset

Tetrahedral Ontological Closure Architecture (TOCA)

Analyst:	Steven Easley, Founder & CEO — Echosphere.io
Date:	February 17, 2026
Filed with OIG:	February 17, 2026
Prior Filing:	Tranche 1 filed with OIG — February 16, 2026

Source:	medicaid-provider-spending.csv (10.32 GB)
Released:	February 13, 2026 — DOGE/HHS via opendata.hhs.gov
Coverage:	Bytes 2,000,000,000 - 4,128,000,000 (2.128 GB)
Processing:	42 sequential 50MB chunks
Rows:	42,121,118
Payment Band:	$1,181.40 - $2,986.55 per line item
Total Paid:	$79,482,090,946.11
Date Range:	January 2018 - December 2024

805	$1.04T	289+	6
Total Findings	Dollars Analyzed	NPIs Flagged	System Patterns

Filing Record

Tranche	Filed with OIG	Coverage	Rows	Dollars	Findings	NPIs
1	Feb 16, 2026	0-20% (0-2.0 GB)	~28M	~$960B	26	80+
2	Feb 17, 2026	20-40% (2.0-4.1 GB)	42.1M	$79.5B	779	209
TOTAL		**40%**	**~70M**	**~$1.04T**	**805**	**289+**

Overview

This submission covers the second 20% of the DOGE Medicaid Provider Spending dataset (bytes 2.0 GB through 4.1 GB), processed as 42 sequential 50MB chunks. The dataset is sorted by TOTAL_PAID descending, so this tranche spans a payment band from ~$2,987 down to ~$1,181 per line item — the moderate-value billing tier where fraud manifests through volume concentration and billing pattern anomalies.

Three constraint batteries were applied to every chunk: **K-Constraint** (volume impossibility, >400 claims/beneficiary), **R-Constraint** (single-code concentration, 1 code >$100K), and **T-Constraint** (temporal surge, >300% YoY growth).

Constraint	Type	Findings	Description
R-Constraint	Single-Code	95	Providers billing only 1 HCPCS code, >$100K
T-Constraint	Surge Growth	682	Year-over-year growth >300%
K-Constraint	Volume	2	Claims per beneficiary >400
TOTAL		**779**	**209 unique NPIs flagged**

Analysis 1: Single-Code Providers Over $100K — R-Constraint

95 providers in the 20-40% band bill exclusively one HCPCS code with cumulative payments exceeding $100,000. Single-code billing at this scale and duration is structurally inconsistent with legitimate clinical practice.

Code	Description	Providers	Total Paid
T1017	Targeted Case Management	32	$5,165,597
T1015	Clinic Visit/Encounter	25	$2,879,211
99285	ED Visit Level 5	11	$1,293,367
97110	Therapeutic Exercise	8	$1,156,989
99451	Virtual Check-In	5	$532,155
0450	Emergency Room	3	$397,040
01967	Anesthesia	3	$364,755
H0004	Behavioral Health	2	$309,293
90837	Psychotherapy 60min	2	$226,263
Other	(4 codes)	4	$538,564
TOTAL		**95**	**$12,863,234**

Pattern 1 Confirmation: T1017 (32) + T1015 (25) = 57 of 95 single-code providers (60%) are case management codes, directly extending Pattern 1 (T1015 Phantom Clinics, $13.3B in Tranche 1) into the moderate-payment tier.

Critical Finding — NPI 1962628289: This provider appears as a single-code T1017 biller in 13 of 42 chunks, spanning the entire $1,181-$2,987 payment band. Cross-chunk persistence with a single code is the strongest possible indicator of an entity created solely to bill case management.

Top 15 Single-Code Providers by Total Paid

NPI	Code	Months	Claims	Benes	Total Paid
1669457859	97110	48	3,921	1,340	$235,519
1942370762	0510	55	2,728	2,524	$223,732
1962628289	T1017	55	8,431	3,330	$221,175
1316945090	H0004	49	2,843	1,033	$206,308
1275609158	T1017	45	3,358	1,924	$193,921
1093894172	T1015	33	3,623	3,135	$166,733
1306912241	0450	39	2,035	2,022	$164,497
1902957103	01967	47	1,117	1,008	$138,786
1306210224	99285	39	1,306	1,253	$137,288
1487604641	99285	36	1,760	1,554	$133,676
1376714543	99285	29	1,569	1,447	$132,280

1225029051	T1015	31	1,251	981	$127,018
1124491477	99285	35	1,222	1,196	$123,062
1841490075	T1015	31	635	598	$120,533
1811288731	90837	27	1,641	950	$120,332

Analysis 2: Surge Growth >300% YoY — T-Constraint

682 provider-code pairs show year-over-year billing growth exceeding 300%. The surge distribution reveals E&M; (Evaluation and Management) codes comprise 78.3% of all surges — now designated **Pattern 6: E&M; Upcoding Epidemic**.

Surge Distribution by Code

Code	Surges	Avg Growth	Current-Year Total
99214	191	446.4%	$16,427,841
99213	133	565.5%	$15,311,338
99285	97	448.2%	$7,889,289
99284	96	407.5%	$6,819,216
G0463	31	443.8%	$2,561,022
87426	29	546.8%	$3,626,699
99283	17	388.2%	$1,089,204
99203	11	626.4%	$1,162,043
90837	5	401.4%	$395,711
99211	5	386.4%	$287,297
92004	5	331.4%	$328,116
90670	5	778.9%	$582,299
99215	4	373.0%	$224,089
99201	4	374.0%	$279,812
99392	4	402.9%	$293,092

Top 25 Surge Findings by Growth Rate

NPI	Code	Period	Prev Paid	Curr Paid	Growth
1730491945	99214	2020-2021	$14,009	$423,143	2920.6%
1811062763	99213	2020-2021	$16,979	$374,378	2104.9%
1730491945	99213	2020-2021	$12,460	$266,613	2039.8%
1811062763	99213	2020-2021	$13,242	$271,443	1949.8%
1730491945	99213	2020-2021	$13,351	$258,297	1834.7%
1811062763	99213	2019-2020	$10,325	$194,021	1779.2%
1811062763	99213	2019-2020	$10,956	$203,625	1758.6%
1730491945	99203	2020-2021	$13,133	$236,710	1702.4%
1811062763	99213	2019-2020	$11,138	$195,164	1652.3%
1730491945	99213	2020-2021	$12,919	$220,516	1606.9%
1811062763	99213	2020-2021	$25,680	$365,424	1323.0%
1811062763	99213	2020-2021	$17,675	$247,320	1299.2%

1548343510	99214	2023-2024	$10,406	$140,754	1252.6%
1811062763	99213	2019-2020	$16,766	$218,848	1205.3%
1184786527	99214	2018-2019	$22,764	$296,767	1203.7%
1811062763	99213	2019-2020	$10,368	$131,581	1169.1%
1730491945	99213	2020-2021	$10,344	$125,636	1114.6%
1366515488	G0463	2022-2023	$11,753	$141,297	1102.2%
1043917180	99285	2023-2024	$10,030	$120,416	1100.5%
1730491945	87426	2020-2021	$10,855	$128,060	1079.7%
1811062763	99214	2020-2021	$15,486	$181,872	1074.4%
1639138480	90670	2022-2023	$12,624	$147,481	1068.3%
1730491945	99213	2020-2021	$14,829	$172,050	1060.3%
1043917180	99285	2023-2024	$12,286	$141,835	1054.4%
1730491945	99213	2020-2021	$23,401	$254,985	989.6%

Critical Surge Findings

NPI 1730491945 — Peak surge 2,920.6% on 99214 (Level 4 office visit, 2020-2021). Appears in 12+ surge findings across codes 99214, 99213, 99203, and 87426. A nearly 30x increase in Level 4 billing is not organic growth — it is a billing system activation event. Cross-code surging indicates practice-wide billing escalation.

NPI 1811062763 — Peak surge 2,104.9% on 99213 (2020-2021). Appears across 15+ findings spanning multiple payment tiers. Surging on in-person office visit codes during COVID-era reduced access is structurally suspect.

NPI 1548343510 — 1,252.6% surge on 99214 in 2023-2024. This is NOT a COVID artifact — billing manipulation continues into the most recent data period.

E&M; dominance: 99214 + 99213 + 99285 + 99284 + 99283 = 534 of 682 surges (78.3%). This is a structural deficiency in Medicaid E&M; reimbursement verification, not a collection of individual anomalies.

Analysis 3: Claims-per-Beneficiary >400 — K-Constraint

Two volume impossibilities detected in this payment band:

NPI 1720171895 — Code 99211 (Office Visit Level 1), April 2024. 6,491 claims for 12 beneficiaries = 540.9 per patient = ~18 visits per patient per day for 30 days. Physically impossible.

NPI 1639172869 — Code J3490 (Unclassified Drug), December 2022. 17,947 claims for 41 beneficiaries = 437.7 per patient. J3490 is a catch-all code frequently associated with fraud — it allows billing without specifying which drug was administered.

K-constraint violations are sparse at this payment tier ($1,181-$2,987). Extreme claim-stacking more commonly produces very low per-line payments. K-constraint yields will increase dramatically in the 40-60% band.

System Pattern Update — Cumulative

#	Pattern	Status	Key Metric	Tranche
1	T1015/T1017 Phantom Clinics	CONFIRMED EXPANDING	$13.3B + 57 new providers	1, 2
2	DC Behavioral Health	CONFIRMED	$380M+, 13 providers, 1 DOJ	1
3	Michigan H2015	CONFIRMED	15+ providers statewide	1
4	Multi-State H2015	CONFIRMED	MI/IL/NC coordination	1
5	New Entity Flooding	CONFIRMED	$3.07B, 16,677 entities	1
6	E&M Upcoding Epidemic	CONFIRMED (NEW)	78% of surges, 534 findings	2

Full-Dataset Projection from 40% Sample

Pattern	40% Sample	Full Dataset (Est.)
T1015/T1017 phantom clinics	$13.3B / 9,285+ providers	$15-20B / 12-15K providers
New entity flooding	$3.07B / 16,677 entities	$8-15B / 40K+ entities
DC behavioral health	$380M+ / 13 providers	$400M+ (fully captured)
National H-code behavioral	Emerging	$1B+
Drug testing mills	$190.6M	$500M+ (est.)
E&M upcoding epidemic	534 surges / 78% of findings	Under quantification
Physically impossible billing	Dozens of cases	Hundreds of cases
Regional clusters	2 confirmed (DC, MI)	5-10 estimated
TOTAL FLAGGED EXPOSURE	**$17B+**	**$30-50B**

Legal Basis & Declaration

This analysis constitutes original analytical work product derived from publicly released federal data. The Tetrahedral Ontological Closure Architecture (TOCA) is proprietary to Echosphere.io and protected by eight patent families (A-I) filed with the USPTO.

Submitted under the Anti-Money Laundering Act whistleblower provisions (31 U.S.C. 5323) and Secretary Bessent's announced bounty program (10-30% recovery on identified fraud).

The submitter has developed an automated analytical engine capable of processing the full 10.32 GB dataset and classifying anomalies at scale. This is the second of five planned tranche submissions covering the complete dataset. The submitter welcomes direct engagement regarding application of this system to federal fraud detection efforts.

Steven Easley

Founder & CEO, Echosphere.io

Filed: February 17, 2026

Echosphere.io | TOCA | Patent Families A-I

Methodological Disclosure & Legal Notice

This analysis identifies statistical anomalies in publicly released federal data. **No finding in this report constitutes an accusation of fraud against any individual, entity, or organization.** The providers, NPIs, and billing patterns identified herein are flagged solely as deviations from expected statistical norms that are consistent with indicators of potential fraud as recognized by the following cognizant bodies and professional standards.

Professional Standards & Authorities Referenced

HHS Office of Inspector General (OIG): Fraud indicators including billing for services not rendered, upcoding, unbundling, and services not medically necessary (42 CFR 455.2; OIG Work Plan, annually updated).

Association of Certified Fraud Examiners (ACFE): Anomaly-based detection methodology consistent with the ACFE Fraud Examiners Manual, recognizing statistical outlier analysis, temporal surge detection, and concentration analysis as accepted forensic accounting techniques for identifying indicators of potential fraud.

American Institute of Certified Public Accountants (AICPA): AU-C Section 240, "Consideration of Fraud in a Financial Statement Audit," establishing that unusual relationships, transactions inconsistent with expected patterns, and significant deviations from industry norms constitute risk factors warranting further investigation.

Government Accountability Office (GAO): Yellow Book standards (Government Auditing Standards) recognizing data analytics as a valid methodology for identifying conditions that may indicate fraud, waste, or abuse in government programs.

Centers for Medicare & Medicaid Services (CMS): Program Integrity Manual (Chapter 4), defining fraud indicators including patterns inconsistent with generally accepted medical practice, statistically aberrant billing volumes, and abrupt changes in billing patterns.

Department of Justice (DOJ): False Claims Act (31 U.S.C. 3729-3733) framework, under which the identification and reporting of potential fraud against federal programs is a protected activity.

Nature and Limitations of Findings

The TOCA methodology applies three constraint-based tests: **K-Constraint** (volume impossibility), **R-Constraint** (single-code concentration), and **T-Constraint** (temporal surge). Each finding represents an anomaly warranting further investigation by qualified authorities — not a determination of wrongdoing.

Confirming fraud requires additional investigation including: medical record review and clinical documentation audit; on-site inspection and patient verification; corporate registration and beneficial ownership verification; financial flow analysis; interview of providers, patients, and referring physicians; cross-referencing with OIG exclusion lists and state licensing boards; and law enforcement investigation with subpoena authority. **This analysis performs none of these investigative steps.**

Legitimate explanations may exist for some flagged patterns, including specialist scope of practice (R-constraint), pandemic-era billing volatility (T-constraint), and data reporting anomalies. The methodology is designed as a screening tool that minimizes false negatives; some false positives are expected and do not indicate wrongdoing.

Supplemental Open-Source Verification

For a subset of flagged providers, independent open-source verification was conducted using publicly available records — separate from the TOCA statistical methodology. These checks included:

Business license verification: State Secretary of State records checked for corporate status, formation date, registered agents, and cross-entity officer overlap.

Property and address validation: Billing addresses cross-referenced against county assessor databases, satellite imagery, and property records to verify consistency with claimed clinical services.

Identity and registration checks: NPPES registry data reviewed for authorized official patterns consistent with shell organization networks and NPI laundering.

Public commentary review: Google Reviews, state licensing board complaints, and publicly available patient reports checked for consistency with detected billing anomalies.

These supplemental checks produced findings consistent with the TOCA statistical analysis, including expired business licenses on active billing entities, residential addresses claimed as clinical facilities, and patient complaints describing services billed but never rendered. These corroborations are illustrative; comprehensive verification at scale requires investigative resources beyond the scope of this analysis.

DOJ Validation

One entity flagged by TOCA — Prestige Healthcare Resources, LLC (NPI 1144516824, Washington, D.C.) — was independently validated against a Department of Justice indictment for Medicaid fraud. This validation was performed after the TOCA analysis flagged the entity, demonstrating methodology alignment with federal law enforcement findings. This single validation does not establish that all flagged entities are engaged in fraud; it demonstrates that the methodology produces results consistent with confirmed federal fraud prosecution targets.

Data Source, Qualifications & Protections

All analysis is derived from medicaid-provider-spending.csv (10.32 GB), released February 13, 2026, by DOGE/HHS via opendata.hhs.gov — a public record. NPI numbers are public identifiers maintained by CMS in the NPPES registry. No protected health information (PHI) was accessed.

The submitter, Steven Easley (Founder/CEO, Echosphere.io), is not a licensed auditor, certified fraud examiner, or medical professional. The TOCA methodology is proprietary and protected by eight patent families (A-I) filed with the USPTO. Findings are submitted in good faith under protections of the False Claims Act (31 U.S.C. 3729-3733) and the Anti-Money Laundering Act whistleblower provisions (31 U.S.C. 5323).

Nothing in this report constitutes legal, medical, financial, or professional advice. Recipients should consult qualified professionals before taking action based on these findings.