



Department of Justice
Office of Public Affairs

FOR IMMEDIATE RELEASE

Wednesday, June 22, 2016

National Health Care Fraud Takedown Results in Charges against 301 Individuals for Approximately \$900 Million in False Billing

Most Defendants Charged and Largest Alleged Loss Amount in Strike Force History

Attorney General Loretta E. Lynch and Department of Health and Human Services (HHS) Secretary Sylvia Mathews Burwell announced today an unprecedented nationwide sweep led by the Medicare Fraud Strike Force in 36 federal districts, resulting in criminal and civil charges against 301 individuals, including 61 doctors, nurses and other licensed medical professionals, for their alleged participation in health care fraud schemes involving approximately \$900 million in false billings. Twenty-three state Medicaid Fraud Control Units also participated in today's arrests. In addition, the HHS Centers for Medicare & Medicaid Services (CMS) is suspending payment to a number of providers using its suspension authority provided in the Affordable Care Act. This coordinated takedown is the largest in history, both in terms of the number of defendants charged and loss amount.

Attorney General Lynch and Secretary Burwell were joined in the announcement by Assistant Attorney General Leslie R. Caldwell of the Justice Department's Criminal Division, FBI Associate Deputy Director David Bowdich, Inspector General Daniel Levinson of the HHS Office of Inspector General (OIG), Acting Director Dermot O'Reilly of the Defense Criminal Investigative Service (DCIS), and Deputy Administrator and Director of CMS Center for Program Integrity Shantanu Agrawal M.D.

The defendants announced today are charged with various health care fraud-related crimes, including conspiracy to commit health care fraud, violations of the anti-kickback statutes, money laundering and aggravated identity theft. The charges are based on a variety of alleged fraud schemes involving various medical treatments and services, including home health care, psychotherapy, physical and occupational therapy, durable medical equipment (DME) and prescription drugs. More than 60 of the defendants arrested are charged with fraud related to the Medicare prescription drug benefit program known as Part D, which is the fastest-growing component of the Medicare program overall.

“As this takedown should make clear, health care fraud is not an abstract violation or benign offense – It is a serious crime,” said Attorney General Lynch. “The wrongdoers that we pursue in these operations seek to use public funds for private enrichment. They target real people – many of them in need of significant medical care. They promise effective cures and therapies, but they provide none. Above all, they abuse basic bonds of trust – between doctor and patient; between pharmacist and doctor; between taxpayer and government – and pervert them to their own ends. The Department of Justice is determined to continue working to ensure that the American people know that their health care system works for them – and them alone.”

“Millions of seniors depend on Medicare for essential health coverage, and our action shows that this administration remains committed to cracking down on individuals who try to defraud the program,” said Secretary Burwell. “We are continuing to put new tools and additional resources to work, including \$350 million from the Affordable Care Act, for health care fraud prevention and enforcement efforts. Thanks to the hard work of the Medicare Fraud Strike Force, we are making progress in addressing and deterring fraud and delivering results to help ensure Medicare remains strong for years to come.”

According to court documents, the defendants allegedly participated in schemes to submit claims to Medicare and Medicaid for treatments that were medically unnecessary and often never provided. In many cases, patient recruiters, Medicare beneficiaries and other co-conspirators were allegedly paid cash kickbacks in return for supplying beneficiary information to providers, so that the providers could then submit fraudulent bills to Medicare for services that were medically unnecessary or never performed. Collectively, the doctors, nurses, licensed medical professionals, health care company owners and others charged are accused of submitting a total of approximately \$900 million in fraudulent billing.

“The Medicare Fraud Strike Force is a model of 21st-Century data-driven law enforcement, and it has had a remarkable impact on health care fraud across the country,” said Assistant Attorney General Caldwell. “As the cases announced today demonstrate, the Strike Force’s strategic approach keeps us a step ahead of emerging fraud trends, including drug diversion, and fraud involving compounded medications and hospice care.”

“These criminals target the most vulnerable in our society by taking money away from the care of the elderly, children and disabled,” said Associate Deputy Director Bowdich. “The FBI is committed to working with our partners and the public to stop fraud and ensure that healthcare dollars are used to help the sick, and not line the pockets of criminals.”

“While it is impossible to accurately pinpoint the true cost of fraud in federal health care programs, fraud is a significant threat to the programs’ stability and endangers access to health care services for millions of Americans,” said Inspector General Levinson. “As members of the joint Strike Force, OIG will continue to play a vital role in tracking down these criminals and seeing that justice is done.”

“DCIS, in partnership with our fellow federal investigative agencies, will continue to uncompromisingly investigate and bring to justice the people who perpetrate these criminal

acts,” said Acting Director O’Reilly. “Their actions threaten to cripple our vital national health care industry, and place our citizenry at risk. We will remain vigilant.”

“Taxpayers and Congress provided CMS with resources to adopt powerful monitoring systems that fight fraud, safeguard program dollars, and protect Medicare and Medicaid,” said Deputy Administrator and Center for Program Integrity Director Agrawal. “The diligent use of innovative data analytic systems has contributed or led directly to many of the law enforcement cases presented here today. CMS is committed to its collaboration with these agencies to keep federally-funded health care programs safe and strong for all Americans.”

The Medicare Fraud Strike Force operations are part of the Health Care Fraud Prevention & Enforcement Action Team (HEAT), a joint initiative announced in May 2009 between the Department of Justice and HHS to focus their efforts to prevent and deter fraud and enforce current anti-fraud laws around the country. The Medicare Fraud Strike Force operates in nine locations and since its inception in March 2007 has charged over 2,900 defendants who collectively have falsely billed the Medicare program for over \$8.9 billion.

Including today’s enforcement actions, nearly 1,200 individuals have been charged in national takedown operations, which have involved more than \$3.4 billion in fraudulent billings. Today’s announcement marks the second time that districts outside of Strike Force locations participated in a national takedown, and they accounted for 82 defendants charged in this takedown.

For the Strike Force locations, in the Southern District of Florida, a total of 100 defendants were charged with offenses relating to their participation in various fraud schemes involving approximately \$220 million in false billings for home health care, mental health services and pharmacy fraud. In one case, nine defendants have been charged with operating six different Miami-area home health companies for the purpose of submitting false and fraudulent claims to Medicare, including for services that were not medically necessary and that were based on bribes and kickbacks. In total, Medicare paid the six companies over \$24 million as a result of the scheme.

In the Southern District of Texas, 24 individuals were charged in cases involving over \$146 million in alleged fraud. One of these defendants is a physician with the highest number of referrals for home health services in the Southern District of Texas. This physician has been charged with participating in separate schemes to bill Medicare for medically unnecessary home health services that were often not provided. Numerous companies that submitted claims to Medicare using the fraudulent home health referrals from the physician were paid over \$38 million by Medicare.

In the Northern District of Texas, 11 people were charged in cases involving over \$47 million in alleged fraud. In one scheme, a physician allowed unlicensed individuals to perform physician services and then billed Medicare as if he performed them. Additionally, the physician certified patients for home health care that was often medically unnecessary. Home health companies

submitted approximately \$23.3 million in billings to Medicare based on the physician's fraudulent certifications.

In the Central District of California, 22 defendants were charged for their roles in schemes to defraud Medicare of approximately \$162 million. In one case, a doctor was charged with causing almost \$12 million in losses to Medicare through his own fraudulent billing, including performing medically unnecessary vein ablation procedures on Medicare beneficiaries.

In the Eastern District of Michigan, 19 defendants face charges for their alleged roles in fraud, kickback, money laundering and drug distribution schemes involving approximately \$114 million in false claims for services that were medically unnecessary or never rendered. Among these are owners of a physical therapy clinic who lured patients through the payment of cash kickbacks and medically unnecessary prescriptions for Schedule II medications for the purpose of stealing more than \$36 million from Medicare.

In Tampa, Orlando and elsewhere in the Middle District of Florida, 15 individuals were charged with participating in a variety of schemes including compounding pharmacy fraud and intravenous prescription drug fraud involving \$17 million in fraudulent billing. In one case, the owner of several infusion clinics allegedly defrauded the Medicare program of over \$8 million through a scheme involving reimbursement claims for expensive intravenous prescription drugs that were never purchased and never administered to patients.

In the Northern District of Illinois, six individuals were charged in cases related to three different schemes involving bribery and false and fraudulent claims for home health services and disability benefits. The charged defendants include individuals who owned or co-owned the fraudulent providers and a medical doctor. In total, these schemes resulted in over \$12 million being paid to the defendants and their companies.

In the Eastern District of New York, 10 individuals were charged in six different cases, including five individuals who were charged for their roles in a scheme involving over \$86 million in physical and occupational therapy claims to Medicare and Medicaid. In that case, the defendants are alleged to have filled a network of Brooklyn clinics that they controlled with patients by paying bribes and kickbacks. Once at the clinics, these patients were subjected to medically unnecessary therapy. The defendants then laundered the proceeds of the fraud through over a dozen shell companies.

In the Eastern District of Louisiana, three defendants were charged in connection with a health care fraud and wire fraud conspiracy involving a defunct home health care provider. This scheme centered on the payment of kickbacks through patient recruiters in exchange for patients who oftentimes never received nor qualified for home health care as billed. Once admitted, patient medical records were routinely fabricated and altered to support false and fraudulent claims to Medicare.

In addition to the Strike Force, today's enforcement actions include cases brought by 26 U.S. Attorney's Offices, including the unsealing of search warrants in investigations being conducted by the Eastern District of North Carolina, Southern District of Georgia, District of Columbia, Eastern District of Texas, Southern District of West Virginia, Middle District of Louisiana, District of Minnesota, and the Northern District of Alabama.

In the Northern District of Georgia, nine defendants were charged for their roles in two health care fraud schemes involving \$7 million in fraudulent billings. Eight defendants were charged in a scheme where bribes and kickbacks were allegedly paid to a state of Georgia official in exchange for falsifying applications and licensing requirements and recommending the approval of unqualified mental health providers.

In the Middle District of Alabama, two defendants were charged for their roles in a mental health services scheme allegedly involving \$246,000 in fraudulent billings.

In the Middle District of Tennessee, a doctor was charged for his role in an illegal kickback scheme under which he allegedly referred patients to a certain DME supplier in exchange for cash kickbacks.

In the Western District of Kentucky, a business entity was charged for its role in a health care fraud scheme.

In the Southern District of Ohio, two defendants were charged for their roles in a \$7.5 million home healthcare fraud scheme.

In the Western and Eastern Districts of Pennsylvania, three defendants were charged for their roles in drug diversion and embezzlement schemes.

In the Southern District of New York, a pharmacist was charged for his role in a scheme involving over \$51 million in fraudulent Medicare and Medicaid billings.

In the Districts of Maine, Alaska, Kansas, Connecticut and Vermont, five defendants were charged for their roles in Medicaid-related schemes.

In the Eastern District of Missouri, four defendants, including a doctor and pharmacist, were charged for their roles in schemes involving over \$3 million in billings.

In the Southern District of California, eight individuals were charged in health care-related cases. In one case, five individuals, including a doctor and a pharmacist, were charged in a scheme to pay bribes and kickbacks to doctors in exchange for prescribing expensive durable medical equipment and compound pain creams that were not medically necessary. The indictment alleges that approximately \$27 million in false and fraudulent claims were submitted to insurers.

In the District of New Mexico, two defendants were charged for their roles in a Medicaid fraud scheme.

In the Northern District of Iowa, a settlement agreement was reached with a corporate entity for its role in a health care fraud scheme in a juvenile residential treatment facility.

In the District of Oregon, one defendant was charged for his role in a \$1.7 million optometry services scheme.

In the District of Puerto Rico, civil demand letters were issued to six individuals for their roles in a scheme to defraud the Medicaid program.

In addition, in the states of Florida, Iowa, South Dakota, Indiana, New York, Michigan, Oklahoma, Rhode Island, Louisiana, Pennsylvania, New Hampshire, Oregon, Kentucky and Alaska, 49 defendants have been charged in criminal and civil actions with defrauding the Medicaid program and 57 sites were searched, pursuant to search warrants. These cases were investigated by each state's respective Medicaid Fraud Control Units.

The cases announced today are being prosecuted and investigated by U.S. Attorneys' Offices nationwide, along with Medicare Fraud Strike Force teams from the Criminal Division's Fraud Section and from the U.S. Attorney's Offices of the Southern District of Florida, Eastern District of Michigan, Eastern District of New York, Southern District of Texas, Central District of California, Eastern District of Louisiana, Northern District of Texas, Northern District of Illinois and the Middle District of Florida; and agents from the FBI, HHS-OIG, Drug Enforcement Administration, DCIS and state Medicaid Fraud Control Units.

A complaint or indictment is merely a charge, and all defendants are presumed innocent unless and until proven guilty.

The court documents for each case will be posted online, as they become available, here: <https://www.justice.gov/opa/documents-and-resources-june-22-2016-medicare-fraud-strike-force-press-conference>.

The Affordable Care Act has provided new tools and resources to fight fraud in federal health care programs. The law provides an additional \$350 million for health care fraud prevention and enforcement efforts, which has allowed the department to hire more prosecutors and the Strike Force to expand from two cities to nine. The act also toughens sentencing for criminal activity, enhances provider and supplier screenings and enrollment requirements and encourages increased sharing of data across government.

In addition to providing new tools and resources to fight fraud, the Affordable Care Act clarified that for sentencing purposes, the loss is determined by the amount billed to Medicare and increased the sentencing guidelines for the billed amounts, which has provided a strong deterrent effect due to increased prison time, particularly in the most egregious cases.

Since January 2009, the Justice Department's Civil Division, along with U.S. Attorney's Offices around the country, has recovered a total of more than \$29.9 billion through False Claims Act cases, with more than \$18.3 billion of that amount recovered in cases involving fraud against federal health care programs.

