JUSTICE NEWS

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Medicare Fraud Strike Force Charges 91 Individuals for Approximately $430 Million in False Billing

Medicare Fraud Strike Force operations in seven cities have led to charges against 91 individuals – including doctors, nurses and other licensed medical professionals – for their alleged participation in Medicare fraud schemes involving approximately $429.2 million in false billing, Attorney General Eric Holder and Health and Human Services (HHS) Secretary Kathleen Sebelius announced today.

Attorney General Holder and Secretary Sebelius were joined in the announcement of the nationwide takedown by Assistant Attorney General Lanny A. Breuer of the Justice Department's Criminal Division, FBI Associate Deputy Director Kevin Perkins, Inspector General Daniel R. Levinson of the HHS Office of Inspector General (HHS-OIG) and Dr. Peter Budetti, Deputy Administrator for Program Integrity of the Centers for Medicare and Medicaid Services (CMS).

"Today's enforcement actions reveal an alarming and unacceptable trend of individuals attempting to exploit federal health care programs to steal billions in taxpayer dollars for personal gain," said Attorney General Holder. "Such activities not only siphon precious taxpayer resources, drive up health care costs, and jeopardize the strength of the Medicare program – they also disproportionately victimize the most vulnerable members of society, including elderly, disabled and impoverished Americans."

"Today's arrests put criminals on notice that we are cracking down hard on people who want to steal from Medicare," said HHS Secretary Sebelius. "The health care law gives us new tools to better fight fraud and make Medicare stronger. In addition to the arrests made today, HHS used new authority from the health care law to stop future payments to many of the health care providers suspected of fraud, saving Medicare resources and taxpayer dollars from being lost to fraud in the first place."

Dozens of charged individuals were arrested or surrendered in the last 24 hours as indictments were unsealed across the country. Together, those indictments charge more than $230 million in home health care fraud; more than $100 million in mental health care fraud and more than $49 million in ambulance transportation fraud; and millions more in other frauds.

HHS also suspended or took other administrative action against 30 health care providers following a data-driven analysis and based upon credible allegations of fraud. Under the Affordable Care Act, HHS is able to suspend payments until the resolution of an investigation.

The joint Department of Justice and HHS Medicare Fraud Strike Force is a multi-agency team of federal, state and local investigators and prosecutors designed to combat Medicare fraud through the use of Medicare data analysis techniques. More than 500 law enforcement agents from the FBI, HHS-OIG, multiple Medicaid Fraud Control Units, and other state and local law enforcement agencies participated in the takedown.

The defendants charged are accused of various health care fraud-related crimes, including conspiracy to commit health care fraud, health care fraud, violations of the anti-kickback statutes and money laundering. The charges are based on a variety of alleged fraud schemes involving various medical treatments and services such as home health care, mental health services, psychotherapy, physical and

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occupational therapy, durable medical equipment (DME) and ambulance services.

According to court documents, the defendants allegedly participated in schemes to submit claims to Medicare for treatments that were medically unnecessary and oftentimes never provided. In many cases, court documents allege that patient recruiters, Medicare beneficiaries and other co-conspirators were paid cash kickbacks in return for supplying beneficiary information to providers, so that the providers could submit fraudulent billing to Medicare for services that were medically unnecessary or never provided. Collectively, the doctors, nurses, licensed medical professionals, health care company owners and others charged are accused of conspiring to submit a total of approximately $429.2 million in fraudulent billing.

"Today's coordinated actions represent one of the largest Medicare fraud takedowns in Department of Justice history, as measured by the amount of alleged fraudulent billings," said Assistant Attorney General Breuer. "We have made it one of the Department's missions to hold accountable those who abuse the Medicare program for personal profit. And there are Medicare fraudsters in prisons across the country – some who will be there for decades – who can attest to our determination, and our effectiveness."

"Health care fraud leads to higher health care costs and makes quality care more difficult to obtain," said FBI Associate Deputy Director Perkins. "Working together to stop fraud, as we did today, will ensure that Americans' hard-earned dollars are used to care for the sick – not to line the pockets of criminals."

"Today's coordinated operation demonstrates that law enforcement is flexible enough to address health care fraud in its many evolving forms," said HHS Inspector General Levinson. "When home health agencies, durable medical equipment companies, pharmacies, or other health care providers are suspected of breaking the law, they can expect to be caught and held accountable."

"This is the result of coordinated anti-fraud efforts – including Medicare flagging suspicious activity,

efforts between agencies to investigate this criminal activity, and today's actions by law enforcement and HHS," said CMS Deputy Administrator for Program Integrity Budetti. "As we stop payments to these providers suspected of fraud, we continue our efforts to move from a pay-and-chase model to one where we stop fraudsters before they can successfully bill Medicare and Medicaid."

In Miami, a total of 33 defendants are charged for their alleged participation in various fraud schemes involving a total of $204.5 million in false billings for home health care, mental health services, occupational and physical therapy, and DME. In one case, three defendants are charged for participating in a fraud scheme at LTC Professional Consultants and Professional Home Care Solutions Inc. which led to approximately $74 million in fraudulent billing for home health care. In another case, five defendants are charged for participating in a fraud scheme at Hollywood Pavilion which led to $67 million in fraudulent billing for mental health services.

Sixteen individuals, including three doctors and one licensed physical therapist, are charged in Los Angeles with participating in various fraud schemes involving a total of $53.8 million in false billings. In one case, four defendants are charged for allegedly participating in a fraud scheme at Alpha Ambulance Inc., which led to approximately $49.2 million in fraudulent billing for ambulance transportation. The case represents the largest ambulance fraud scheme ever prosecuted by the Medicare Fraud Strike Force. According to court documents, the defendants provided beneficiaries ambulance rides that were medically unnecessary.

In Dallas, 14 individuals – including two doctors and two registered nurses – are charged for their alleged participation in various fraud schemes involving a total of $103.3 million in false billings. In one case, three defendants – a medical doctor and two registered nurses – are charged with participating in a fraud scheme at Raphem Medical Practice and PTM Healthcare Services which led to approximately $100 million in fraudulent billing for home health care services. According to court documents, Dr. Joseph Megwa signed approximately 33,000 prescriptions for more than 2,000 unique Medicare beneficiaries from 2006 to 2011. Many of these Medicare beneficiaries had primary care physicians who never certified home healthcare services for them. In order to handle the volume of prescriptions, Megwa allegedly signed stacks of documents without reviewing them.

Seven individuals are charged in Houston for their participation in a fraud scheme at a hospital which led to $158 million in fraudulent billing for community mental health center services. According to court documents, the defendants who served as administrators at the hospital paid kickbacks – in the form of cigarettes, food and coupons redeemable for items available at the hospital's "country stores" – to Medicare beneficiaries in exchange for those beneficiaries' attendance at the hospital's partial hospitalization programs (PHP). Allegedly, beneficiaries watched television, played games and

hospitalization programs (PHP). Allegedly, beneficiaries watched television, played games and engaged in other non-PHP activities rather than receiving the services for which the hospital billed Medicare. Previously, on Feb. 22, 2012, the assistant administrator of the hospital, Mohammad Kahn, pleaded guilty to conspiracy to commit health care fraud and paying kickbacks related to $116 million worth of fraudulent claims submitted to Medicare. After his guilty plea, an additional $42 million in fraudulent claims were discovered that are included in today's totals.

In Brooklyn, 15 individuals, including one doctor and four chiropractors, are charged for their alleged participation in various fraud schemes involving a total of $23.2 million in false billings. In one case, nine defendants, including a medical doctor, are charged with participating in a fraud scheme at Cropsey Medical Care PLLC which led to approximately $13.8 million in fraudulent billing for physical therapy and related services. According to court documents, the defendants paid cash kickbacks to Medicare beneficiaries in exchange for physical therapy that was not medically necessary and on some occasions never provided to beneficiaries.

In Baton Rouge, four defendants, including a licensed practical nurse, are charged for their roles in fraud schemes involving approximately $2.4 million in false claims for medically unnecessary durable medical equipment.

In Chicago, two defendants, including a dermatologist and a psychologist, are charged for their roles in fraud schemes involving, according to court documents, millions of dollars in false claims for medically unnecessary laser treatments and psychotherapy services.

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.

Since their inception in March 2007, strike force operations in nine locations have charged more than 1,480 defendants who collectively have falsely billed the Medicare program for more than $4.8 billion. In addition, the HHS Centers for Medicare and Medicaid Services, working in conjunction with the HHS-OIG, are taking steps to increase accountability and decrease the presence of fraudulent providers.

The cases announced today are being prosecuted and investigated by Medicare Fraud Strike Force teams comprising attorneys from the Fraud Section of the Justice Department's Criminal Division and from the U.S. Attorneys' Offices for the Southern District of Florida, the Southern District of Texas, the Northern District of Texas, the Central District of California, the Middle District of Louisiana, the Northern District of Illinois, and the Eastern District of New York, and agents from the FBI, HHS-OIG and state Medicaid Fraud Control Units, with assistance from the Justice Department's Civil Division and the IRS.

The charges and allegations contained in the indictments are merely accusations and the defendants are presumed innocent unless and until proven guilty.

To learn more about HEAT, go to: www.stopmedicarefraud.gov.

Related Material:

- Assistant Attorney General Lanny A. Breuer Speaks at the Health Care Fraud Takedown Press Conference
- Attorney General Eric Holder Speaks at the Health Care Fraud Takedown Press Conference

12-1205 Attorney General

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