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MEDICARE FRAUD STRIKE FORCE CHARGES 91 INDIVIDUALS FOR APPROXIMATELY $295 MILLION IN FALSE BILLING

WASHINGTON – Attorney General Eric Holder and Health and Human Services (HHS) Secretary Kathleen Sebelius announced today that a nationwide takedown by Medicare Fraud Strike Force operations in eight cities has resulted in charges against 91 defendants, including doctors, nurses, and other medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $295 million in false billing.

Attorney General Holder and Secretary Sebelius were joined in the announcement by FBI Executive Assistant Director Shawn Henry, Assistant Attorney General Lanny A. Breuer of the Justice Department's Criminal Division and HHS Inspector General Daniel R. Levinson.

As part of a coordinated action, 70 individuals were charged by Strike Force prosecutors in indictments unsealed yesterday and today in six cities alleging a variety of Medicare fraud schemes involving approximately $263.6 million in false billings. As part of takedown operations last week, 18 additional defendants were charged in Detroit and one defendant was charged in Miami in cases unsealed on Sept. 1, 2011, for their alleged roles in Medicare fraud schemes involving approximately $29.4 million in fraudulent claims. Additionally, two individuals are scheduled to appear in court today on charges filed on Aug. 24, 2011, for their roles in a separate $2 million health care fraud scheme. This coordinated takedown involved the highest amount of false Medicare billings in a single takedown in Strike Force history.

The joint Department of Justice-HHS Medicare Fraud Strike Force is a multi-agency team of federal, state and local investigators designed to combat Medicare fraud through the use of Medicare data analysis techniques and an increased focus on community policing. Over the course of the past week, approximately 400 law enforcement agents from the FBI, HHS-Office of Inspector General (HHS-OIG), multiple Medicaid Fraud Control Units, and other state and local law enforcement agencies participated in the takedown. In addition to making arrests, agents also executed 18 search warrants in connection with ongoing strike force investigations.

"The defendants charged in this takedown are accused of stealing precious taxpayer resources and defrauding Medicare – jeopardizing the integrity of our health care system and our nation's most critical health care program for personal gain," said Attorney General Holder. "Our highly coordinated, nationwide Strike Force operations are working aggressively to combat Medicare fraud and our anti-health care fraud efforts have never been more innovative, collaborative, aggressive – or effective. We will continue to work with our law enforcement partners and partners across government to fight against health care fraud."

"Today's arrests are a powerful warning to those who would try to defraud taxpayers and Medicare beneficiaries," said HHS Secretary Sebelius. "These arrests illustrate close cooperation between the Medicare program that identified these fraudsters and the law enforcement officials who acted swiftly to cut them off. And our efforts to stop criminals don't end here because the Affordable Care Act gives us new tools to prevent Medicare fraud before it is committed – better protecting seniors and the integrity of the Medicare program for generations to come."

The defendants charged are accused of various health care fraud-related crimes, including conspiracy to defraud the Medicare program, 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, physical and occupational therapy, mental health services, psychotherapy and durable medical equipment (DME).

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, indictments and complaints 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, medical professionals, health care company owners and others charged in the indictments and complaints are accused of conspiring to submit a total of approximately $295 million in fraudulent billing.

"The health care system is part of our nation's infrastructure and we must do everything in our power to protect the integrity of Medicare and the system at large," said FBI Executive Assistant Director Henry. "Working together as partners, we can stop criminals who seek to steal American taxpayers' hard-earned dollars and we help ensure our nation's health care system is there for those who need it."

"As charged in these indictments, the defendants cover nearly the entire spectrum of healthcare providers, and perpetrated a variety of fraudulent schemes," said Assistant Attorney General Breuer. "From Brooklyn to Miami to Los Angeles, the defendants allegedly treated the Medicare program like a personal piggy bank. Today's Strike Force operations should serve as a wake-up call to would-be fraudsters nationwide. With Strike Force teams now in nine cities across the country, and employing sophisticated,

data-driven law enforcement methods, we are determined to hold criminally responsible those who defraud Medicare."

"The warning should be unambiguously clear by now," said HHS Inspector General Levinson. "We will continue using the combined law enforcement might of Strike Forces around the country to combat health care fraud."

In Miami, 45 defendants, including one doctor and one nurse, were charged today and yesterday for their participation in various fraud schemes involving a total of $159 million in false billings for home health care, mental health services, occupational and physical therapy, DME and HIV infusion. Another defendant in Miami was charged on Sept. 1, 2011, for a $1 million Medicare fraud scheme. In one case, 24 defendants are charged for participating in a community mental health center fraud scheme involving more than $50 million in fraudulent billing. According to court documents, the defendants allegedly paid patient recruiters to refer ineligible beneficiaries to the mental health center. In some instances, beneficiaries who were residents of halfway houses were allegedly threatened with eviction if they did not agree to attend the mental health center.

In Houston, two individuals were charged today with fraud schemes involving $62 million in false billings for home health care and DME. According to an indictment, one defendant allegedly sold beneficiary information to 100 different Houston-area home health care agencies in exchange for illegal payments. The indictment alleges that the home agencies then used the beneficiary information to bill Medicare for services that were unnecessary or never provided.

Ten defendants were charged in Baton Rouge, La., for participating in schemes involving more than $24 million related to false claims for home health care and DME. According to one indictment, a doctor, nurse and five other co-conspirators participated in a scheme to bill Medicare for more than $19 million in skilled nursing and other home health services that were medically unnecessary or never provided.

Six defendants, including two doctors, were charged in Los Angeles for their roles in schemes to defraud Medicare of more than $10.7 million. In Brooklyn, three defendants, including two doctors, were charged for a fraud scheme involving more than $3.4 million in false claims for medically unnecessary physical therapy. Two defendants, including a doctor, are making initial appearances today in U.S. federal court in Dallas after being charged for a scheme to defraud Medicare of approximately $2.1 million.

In Detroit, 18 defendants, including three doctors, were charged last week for schemes to defraud Medicare of more than $28 million. According to an indictment, 14 of the defendants participated in a home health care scheme that submitted more than $14 million in false claims to Medicare. Finally, four defendants including one doctor were charged in Chicago for their alleged roles in schemes to defraud Medicare of more than $4.4 million.

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 1,140 defendants who collectively have falsely billed the Medicare program for more than $2.9 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 comprised of attorneys from the Fraud Section of the Justice Department's Criminal Division and from the U.S. Attorney's Offices for the Southern District of Florida, the Eastern District of Michigan, the Eastern District of New York, the Southern District of Texas, the Central District of California, the Middle District of Louisiana; the Northern District of Illinois, and the Northern District of Texas; and agents from the FBI, HHS-OIG, and state Medicaid Fraud Control Units.

An indictment is merely a charge and defendants are presumed innocent until proven guilty.

To learn more about the Health Care Fraud Prevention and Enforcement Action Team (HEAT), go to: www.stopmedicarefraud.gov.

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