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**MEDICARE FRAUD STRIKE FORCE CHARGES 107 INDIVIDUALS FOR  
APPROXIMATELY \$452 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 seven cities has resulted in charges against 107 individuals, including doctors, nurses and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving approximately \$452 million in false billing.

Attorney General Holder and Secretary Sebelius were joined in the announcement by Assistant Attorney General Lanny A. Breuer of the Justice Department’s Criminal Division, FBI Deputy Director Sean Joyce, Deputy Inspector General for Investigations Gary Cantrell 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).

This coordinated takedown involved the highest amount of false Medicare billings in a single takedown in strike force history.

HHS also suspended or took other administrative action against 52 providers following a data-driven analysis and credible allegations of fraud. The new health care law, the Affordable Care Act, significantly increased HHS’s ability to suspend payments until an investigation is complete.

The joint Department of Justice and 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. More than 500 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 20 search warrants in connection with ongoing strike force investigations.

“The results we are announcing today are at the heart of an Administration-wide commitment to protecting American taxpayers from health care fraud, which can drive up costs and threaten the strength and integrity of our health care system,” said Attorney General Holder. “We are determined to bring to justice those who violate our laws and defraud the Medicare

program for personal gain. As today's takedown reflects, our ongoing fight against health care fraud has never been more coordinated and effective."

"Today's arrests send a strong message to criminals that the consequences of committing Medicare fraud are serious," said HHS Secretary Sebelius. "In addition to these arrests, we used new authority from the health care law to stop all future payments to 52 health care providers suspected of fraud before they are ever made. Today's actions are another example of how the Affordable Care Act is helping the Obama Administration fight fraud and strengthen the Medicare program."

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 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 \$452 million in fraudulent billing.

"As charged in the indictments, these fraud schemes were committed by people up and down the chain of healthcare providers," said Assistant Attorney General Breuer. "Today's operations mark the fourth in a series of historic Medicare fraud takedowns over the past two years. These indictments remind us that Medicare is an attractive target for criminals. But it should also remind those criminals that they risk prosecution and prison time every time they submit a false claim."

"Health care fraud is not a victimless crime," said FBI Deputy Director Joyce. "Every person who pays for health care benefits, every business that pays higher insurance costs to cover their employees, every taxpayer who funds Medicare—all are victims. The FBI will continue to work closely with our federal, state and local law enforcement partners to address health care vulnerabilities, fraud and abuse. We will use every tool we have to ensure our health care dollars are used to care for the sick—not to line the pockets of criminals."

“Today over 200 OIG Special Agents, Forensic Examiners and Analysts have deployed throughout the country to ensure that those responsible for committing Medicare fraud are held accountable,” said HHS-OIG Deputy Inspector General Cantrell. “OIG is committed to the strike force model and will continue to use advanced data analytics along with traditional investigative methods to root out those who steal from our Medicare program.”

In Miami, a total of 59 defendants, including three nurses and two therapists, were charged today and yesterday for their participation in various fraud schemes involving a total of \$137 million in false billings for home health care, mental health services, occupational and physical therapy, DME and HIV infusion. Two of these 59 defendants were originally charged in April 2012 but were indicted on additional charges today. In one case, 10 defendants were charged for participating in a fraud scheme at Health Care Solutions Network, which led to approximately \$63 million in fraudulent billing for community mental health center (CMHC) services. Court documents allege that therapists at Health Care Solutions Network were instructed to alter notes and other medical documents to justify CMHC services for beneficiaries who did not need the services.

Seven individuals were charged today in Baton Rouge, La., for participating in a fraud scheme involving \$225 million in false claims for CMHC services. The case represents the largest CMHC-related scheme ever prosecuted by the Medicare Fraud Strike Force. According to court documents, the defendants recruited beneficiaries from nursing homes and homeless shelters, some of whom were drug addicted or mentally ill, and provided them with no services or medically inappropriate services.

In Houston, nine individuals, including one doctor and one nurse, were charged today with fraud schemes involving a total of \$16.4 million in false billings for home health care and ambulance services. According to court documents, the owners and operators of four different ambulance companies billed Medicare for ambulance rides that were medically unnecessary.

Eight defendants, including two doctors, were charged in Los Angeles for their roles in schemes to defraud Medicare of approximately \$14 million. In one case, two individuals allegedly billed Medicare for more than \$8 million in fraudulent billing for DME.

In Detroit, 22 defendants, including four licensed social workers, were charged for their roles in fraud schemes involving approximately \$58 million in false claims for medically unnecessary services, including home health, psychotherapy and infusion therapy.

In Tampa, Fla., a pharmacist was charged with illegal diversion of controlled substances. One defendant was charged last week in Chicago for his alleged role in a scheme to submit approximately \$1 million in false billing to Medicare for 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 1,330 defendants who collectively have falsely billed the Medicare program for more than \$4 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. Attorneys' Offices for the Southern District of Florida, the Eastern District of Michigan, the Southern District of Texas, the Central District of California, the Middle District of Louisiana, the Northern District of Illinois, and the Middle District of Florida, 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 HEAT, go to: [www.stopmedicarefraud.gov](http://www.stopmedicarefraud.gov).

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