Selected Department of Justice Takedowns and Other Case Events

JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE Thursday, July 13, 2017

National Health Care Fraud Takedown Results in Charges Against Over 412 Individuals Responsible for $1.3 Billion in Fraud Losses

Largest Health Care Fraud Enforcement Action in Department of Justice History

Attorney General Jeff Sessions and Department of Health and Human Services (HHS) Secretary Tom Price, M.D., announced today the largest ever health care fraud enforcement action by the Medicare Fraud Strike Force, involving 412 charged defendants across 41 federal districts, including 115 doctors, nurses and other licensed medical professionals, for their alleged participation in health care fraud schemes involving approximately $1.3 billion in false billings. Of those charged, over 120 defendants, including doctors, were charged for their roles in prescribing and distributing opioids and other dangerous narcotics. Thirty state Medicaid Fraud Control Units also participated in today's arrests. In addition, HHS has initiated suspension actions against 295 providers, including doctors, nurses and pharmacists.

Attorney General Sessions and Secretary Price were joined in the announcement by Acting Assistant Attorney General Kenneth A. Blanco of the Justice Department's Criminal Division, Acting Director Andrew McCabe of the FBI, Acting Administrator Chuck Rosenberg of the Drug Enforcement Administration (DEA), Inspector General Daniel Levinson of the HHS Office of Inspector General (OIG), Chief Don Fort of IRS Criminal Investigation, Administrator Seema Verma of the Centers for Medicare and Medicaid Services (CMS), and Deputy Director Kelly P. Mayo of the Defense Criminal Investigative Service (DCIS).

Today's enforcement actions were led and coordinated by the Criminal Division, Fraud Section's Health Care Fraud Unit in conjunction with its Medicare Fraud Strike Force (MFSF) partners, a partnership between the Criminal Division, U.S. Attorney's Offices, the FBI and HHS-OIG. In addition, the operation includes the participation of the DEA, DCIS, and State Medicaid Fraud Control Units.

The charges announced today aggressively target schemes billing Medicare, Medicaid, and TRICARE (a health insurance program for members and veterans of the armed forces and their families) for medically unnecessary prescription drugs and compounded medications that often were never even purchased and/or distributed to beneficiaries. The charges also involve individuals contributing to the opioid epidemic, with a particular focus on medical professionals involved in the unlawful distribution of opioids and other prescription narcotics, a particular focus for the Department. According to the CDC, approximately 91 Americans die every day of an opioid related overdose.

"Too many trusted medical professionals like doctors, nurses, and pharmacists have chosen to violate their oaths and put greed ahead of their patients," said Attorney General Sessions. "Amazingly, some have made their practices into multimillion dollar criminal enterprises. They seem oblivious to the disastrous

consequences of their greed. Their actions not only enrich themselves often at the expense of taxpayers but also feed addictions and cause addictions to start. The consequences are real: emergency rooms, jail cells, futures lost, and graveyards. While today is a historic day, the Department's work is not finished. In fact, it is just beginning. We will continue to find, arrest, prosecute, convict, and incarcerate fraudsters and drug dealers wherever they are."

"Healthcare fraud is not only a criminal act that costs billions of taxpayer dollars - it is an affront to all Americans who rely on our national healthcare programs for access to critical healthcare services and a violation of trust," said Secretary Price. "The United States is home to the world's best medical professionals, but their ability to provide affordable, high-quality care to their patients is jeopardized every time a criminal commits healthcare fraud. That is why this Administration is committed to bringing these criminals to justice, as President Trump demonstrated in his 2017 budget request calling for a new $70 million investment in the Health Care Fraud and Abuse Control Program. The historic results of this year's national takedown represent significant progress toward protecting the integrity and sustainability of Medicare and Medicaid, which we will continue to build upon in the years to come."

According to court documents, the defendants allegedly participated in schemes to submit claims to Medicare, Medicaid and TRICARE for treatments that were medically unnecessary and often never provided. In many cases, patient recruiters, 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. The number of medical professionals charged is particularly significant, because virtually every health care fraud scheme requires a corrupt medical professional to be involved in order for Medicare or Medicaid to pay the fraudulent claims. Aggressively pursuing corrupt medical professionals not only has a deterrent effect on other medical professionals, but also ensures that their licenses can no longer be used to bilk the system.

"This week, thanks to the work of dedicated investigators and analysts, we arrested once-trusted doctors, pharmacists and other medical professionals who were corrupted by greed," said Acting Director McCabe. "The FBI is committed to working with our partners on the front lines of the fight against heath care fraud to stop those who steal from the government and deceive the American public."

"Health care fraud is a reprehensible crime. It not only represents a theft from taxpayers who fund these vital programs, but impacts the millions of Americans who rely on Medicare and Medicaid," said Inspector General Levinson. "In the worst fraud cases, greed overpowers care, putting patients' health at risk. OIG will continue to play a vital leadership role in the Medicare Fraud Strike Force to track down those who abuse important federal health care programs."

"Our enforcement actions underscore the commitment of the Defense Criminal Investigative Service and our partners to vigorously investigate fraud perpetrated against the DoD's TRICARE Program. We will continue to relentlessly investigate health care fraud, ensure the taxpayers' health care dollars are properly spent, and endeavor to guarantee our service members, military retirees, and their dependents receive the high standard of care they deserve," advised Deputy Director Mayo.

"Last year, an estimated 59,000 Americans died from a drug overdose, many linked to the misuse of prescription drugs. This is, quite simply, an epidemic," said Acting Administrator Rosenberg. "There is a great responsibility that goes along with handling controlled prescription drugs, and DEA and its partners remain absolutely committed to fighting the opioid epidemic using all the tools at our disposal."

"Every defendant in today's announcement shares one common trait - greed," said Chief Fort. "The desire for money and material items drove these individuals to perpetrate crimes against our healthcare system and prey upon many of the vulnerable in our society. Thanks to the financial expertise and diligence of IRS-CI special agents, who worked side-by-side with other federal, state and local law enforcement officers to

uncover these schemes, these criminals are off the street and will now face the consequences of their actions."

The Medicare Fraud Strike Force operations are part of a joint initiative 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 nationwide. Since its inception in March 2007, the Medicare Fraud Strike Force has charged over 3500 defendants who collectively have falsely billed the Medicare program for over $12.5 billion.

****

For the Strike Force locations, in the Southern District of Florida, a total of 77 defendants were charged with offenses relating to their participation in various fraud schemes involving over $141 million in false billings for services including home health care, mental health services and pharmacy fraud. In one case, the owner and operator of a purported addiction treatment center and home for recovering addicts and one other individual were charged in a scheme involving the submission of over $58 million in fraudulent medical insurance claims for purported drug treatment services. The allegations include actively recruiting addicted patients to move to South Florida so that the co-conspirators could bill insurance companies for fraudulent treatment and testing, in return for which, the co-conspirators offered kickbacks to patients in the form of gift cards, free airline travel, trips to casinos and strip clubs, and drugs.

In the Eastern District of Michigan, 32 defendants face charges for their alleged roles in fraud, kickback, money laundering and drug diversion schemes involving approximately $218 million in false claims for services that were medically unnecessary or never rendered. In one case, nine defendants, including six physicians, were charged with prescribing medically unnecessary controlled substances, some of which were sold on the street, and billing Medicare for $164 million in facet joint injections, drug testing, and other procedures that were medically unnecessary and/or not provided.

In the Southern District of Texas, 26 individuals were charged in cases involving over $66 million in alleged fraud. Among these defendants are a physician and a clinic owner who were indicted on one count of conspiracy to distribute and dispense controlled substances and three substantive counts of distribution of controlled substances in connection with a purported pain management clinic that is alleged to have been the highest prescribing hydrocodone clinic in Houston, where approximately 60-70 people were seen daily, and were issued medically unnecessary prescriptions for hydrocodone in exchange for approximately $300 cash per visit.

In the Central District of California, 17 defendants were charged for their roles in schemes to defraud Medicare out of approximately $147 million. Two of these defendants were indicted for their alleged involvement in a $41.5 million scheme to defraud Medicare and a private insurer. This was purportedly done by submitting fraudulent claims, and receiving payments for, prescription drugs that were not filled by the pharmacy nor given to patients.

In the Northern District of Illinois, 15 individuals were charged in cases related to six different schemes concerning home health care services and physical therapy fraud, kickbacks, and mail and wire fraud. These schemes involved allegedly over $12.7 million in fraudulent billing. One case allegedly involved $7 million in fraudulent billing to Medicare for home health services that were not necessary nor rendered.

In the Middle District of Florida, 10 individuals were charged with participating in a variety of schemes involving almost $14 million in fraudulent billing. In one case, three defendants were charged in a $4 million scheme to defraud the TRICARE program. In that case, it is alleged that a defendant falsely represented himself to be a retired Lieutenant Commander of the United States Navy Submarine Service. It is alleged

that he did so in order to gain the trust and personal identifying information from TRICARE beneficiaries, many of whom were members and veterans of the armed forces, for use in the scheme.

In the Eastern District of New York, ten individuals were charged with participating in a variety of schemes including kickbacks, services not rendered, and money laundering involving over $151 million in fraudulent billings to Medicare and Medicaid. Approximately $100 million of those fraudulent billings were allegedly part of a scheme in which five health care professionals paid illegal kickbacks in exchange for patient referrals to their own clinics.

In the Southern Louisiana Strike Force, operating in the Middle and Eastern Districts of Louisiana as well as the Southern District of Mississippi, seven defendants were charged in connection with health care fraud, wire fraud, and kickback schemes involving more than $207 million in fraudulent billing. One case involved a pharmacist who was charged with submitting and causing the submission of $192 million in false and fraudulent claims to TRICARE and other health care benefit programs for dispensing compounded medications that were not medically necessary and often based on prescriptions induced by illegal kickback payments.

****

In addition to the Strike Force locations, today's enforcement actions include cases and investigations brought by an additional 31 U.S. Attorney's Offices, including the execution of search warrants in investigations conducted by the Eastern District of California and the Northern District of Ohio.

In the Northern and Southern Districts of Alabama, three defendants were charged for their roles in two health care fraud schemes involving pharmacy fraud and drug diversion.

In the Eastern District of Arkansas, 24 defendants were charged for their roles in three drug diversion schemes that were all investigated by the DEA.

In the Northern and Southern Districts of California, four defendants, including a physician, were charged for their roles in a drug diversion scheme and a health care fraud scheme involving kickbacks.

In the District of Connecticut, three defendants were charged in two health care fraud schemes, including a scheme involving two physicians who fraudulently billed Medicaid for services that were not rendered and for the provision of oxycodone with knowledge that the prescriptions were not medically necessary.

In the Northern and Southern Districts of Georgia, three defendants were charged in two health care fraud schemes involving nearly $1.5 million in fraudulent billing.

In the Southern District of Illinois, five defendants were charged in five separate schemes to defraud the Medicaid program.

In the Northern and Southern Districts of Indiana, at least five defendants were charged in various health care fraud schemes related to the unlawful distribution and dispensing of controlled substances, kickbacks, and services not rendered.

In the Southern District of Iowa, five defendants were charged in two schemes involving the distribution of opioids.

In the Western District of Kentucky, 11 defendants were charged with defrauding the Medicaid program. In one case, four defendants, including three medical professionals, were charged with distributing controlled substances and fraudulently billing the Medicaid program.

In the District of Maine, an office manager was charged with embezzling funds from a medical office.

In the Eastern and Western Districts of Missouri, 16 defendants were charged in schemes involving over $16 million in claims, including 10 defendants charged as part of a scheme involving fraudulent lab testing.

In the District of Nebraska, a dentist was charged with defrauding the Medicaid program.

In the District of Nevada, two defendants, including a physician, were charged in a scheme involving false hospice claims.

In the Northern, Southern, and Western Districts of New York, five defendants, including two physicians and two pharmacists, were charged in schemes involving drug diversion and pharmacy fraud.

In the Southern District of Ohio, five defendants, including four physicians, were charged in connection with schemes involving $12 million in claims to the Medicaid program.

In the District of Puerto Rico, 13 defendants, including three physicians and two pharmacists, were charged in four schemes involving drug diversion, Medicaid fraud, and the theft of funds from a health care program.

In the Eastern District of Tennessee, three defendants were charged in a scheme involving fraudulent billings and the distribution of opioids.

In the Eastern, Northern, and Western Districts of Texas, nine defendants were charged in schemes involving over $42 million in fraudulent billing, including a scheme involving false claims for compounded medications.

In the District of Utah, a nurse practitioner was charged in connection with fraudulently obtaining a controlled substance, tampering with a consumer product, and infecting over seven individuals with Hepatitis C.

In the Eastern District of Virginia, a defendant was charged in connection with a scheme involving identify theft and fraudulent billings to the Medicaid program.

In addition, in the states of Arizona, Arkansas, California, Delaware, Illinois, Iowa, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, New York, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Vermont, Washington and Wisconsin, 96 defendants have been charged in criminal and civil actions with defrauding the Medicaid program out of over $31 million. These cases were investigated by each state's respective Medicaid Fraud Control Units. In addition, the Medicaid Fraud Control Units of the states of Alabama, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Missouri, Nebraska, New York, North Carolina, Ohio, Texas, and Utah participated in the investigation of many of the federal cases discussed above.

The cases announced today are being prosecuted and investigated by U.S. Attorney's 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, information, or indictment is merely an allegation, and all defendants are presumed innocent unless and until proven guilty.

Additional documents related to this announcement will shortly be available here: https://www.justice.gov/opa/documents-and-resources-july-13-2017.

This operation also highlights the great work being done by the Department of Justice's Civil Division. In the past fiscal year, the Department of Justice, including the Civil Division, has collectively won or negotiated over $2.5 billion in judgements and settlements related to matters alleging health care fraud.

Topic(s):
Opioids
Health Care Fraud

Component(s):
Criminal Division
Office of the Attorney General

Press Release Number:
17-768

Updated December 11, 2017

2017 HEALTH CARE FRAUD TAKEDOWN: DAILY STAT BREAKDOWN

Participating Federal Judicial Districts

1. Alabama - Northern
2. Alabama - Southern
3. Arkansas - Eastern
4. California - Central*
5. California - Eastern
6. California - Northern
7. California - Southern
8. Connecticut
9. Florida - Middle*
10. Florida - Southern*
11. Georgia - Northern
12. Georgia - Southern
13. Illinois - Northern*
14. Illinois - Southern
15. Indiana - Northern
16. Indiana - Southern
17. Iowa - Southern
18. Kentucky - Western
19. Louisiana - Eastern*
20. Louisiana - Middle *
21. Maine
22. Michigan - Eastern*
23. Mississippi - Southern
24. Missouri - Eastern
25. Missouri - Western
26. Nebraska
27. Nevada
28. New York - Eastern*
29. New York - Northern
30. New York - Southern
31. New York - Western
32. Ohio - Northern
33. Ohio - Southern
34. Puerto Rico
35. Tennessee - Eastern
36. Texas - Eastern
37. Texas - Northern
38. Texas - Southern*
39. Texas - Western
40. Utah
41. Virginia - Eastern

**Strike Force Location*

Participating MFCUs

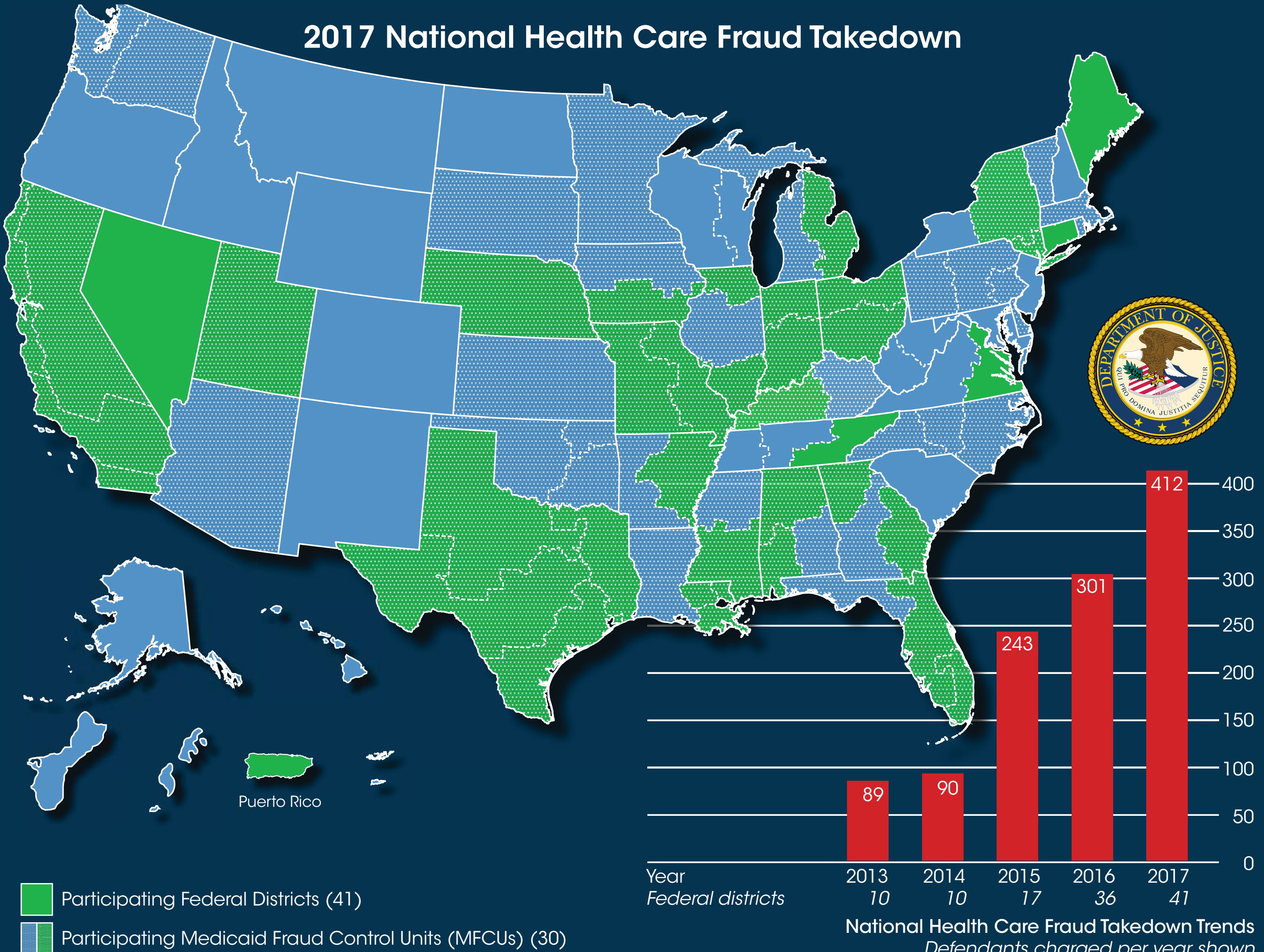
1. Alabama	1. Minnesota
2. Arizona	2. Mississippi
3. Arkansas	3. Missouri
4. California	4. Nebraska
5. Delaware	5. New York
6. Florida	6. North Carolina
7. Georgia	7. Ohio
8. Illinois	8. Oklahoma
9. Indiana	9. Pennsylvania
10. Iowa	10. Rhode Island
11. Louisiana	11. South Dakota
12. Kansas	12. Texas
13. Kentucky	13. Utah
14. Massachusetts	14. Vermont
15. Michigan	15. Washington

National Health Care Fraud Takedown Numbers

FY 2013 – FY 2017

Year	Defendants Charged	Number of Federal Districts Participating
2013	89	10
2014	90	10
2015	243	17
2016	301	36
2017	412	41

**Strike Force Location*



2017 National Health Care Fraud Takedown
Puerto Rico
Participating Federal Districts (41)
Participating Medicaid Fraud Control Units (MFCUs) (30)
DEPARTMENT OF JUSTICE
QUI PRO DOMINA JUSTITIA SEQUITUR
400
350
300
250
200
150
100
50
0
89
90
243
301
412
Year
Federal districts
2013
10
2014
10
2015
17
2016
36
2017
41
National Health Care Fraud Takedown Trends
Defendants charged per year shown

THE UNITED STATES ATTORNEY'S OFFICE
EASTERN DISTRICT of NEW YORK

U.S. Attorneys » Eastern District of New York » News

Department of Justice

U.S. Attorney's Office

Eastern District of New York

FOR IMMEDIATE RELEASE Thursday, July 13, 2017

Three Doctors, A Chiropractor, Three Therapists And Medical Company Owners Arrested In Brooklyn As Part Of National Health Care Fraud Takedown

Alleged Fraudulent Billings in Brooklyn and Queens Exceed $125 Million

Ten individuals, including three doctors, a chiropractor, three licensed physical and occupational therapists and two medical company owners, have been charged for their alleged participation in multiple schemes that fraudulently billed the Medicare and Medicaid programs more than $125 million. The charges filed in federal court in Brooklyn, New York are part of a nationwide health care fraud takedown led by the Medicare Fraud Strike Force, which resulted in criminal charges against 412 individuals for their alleged participation in health care fraud schemes involving approximately $1.3 billion in fraudulent claims.

The Brooklyn and Queens cases were announced by Bridget M. Rohde, Acting United States Attorney for the Eastern District of New York, William F. Sweeney, Jr., Assistant Director-in-Charge, Federal Bureau of Investigation, New York Field Office (FBI), Special Agent in Charge Scott Lampert of the U.S. Department of Health and Human Services - Office of Inspector General (HHS-OIG), New York Regional Office, James D. Robnett, Special Agent-in-Charge, Internal Revenue Service-Criminal Investigation, New York (IRS-CI), and Medicaid Inspector General Dennis Rosen of New York State Office of Medicaid Inspector General (OMIG). The results of the nationwide takedown were announced today by Attorney General Jeff Sessions, Department of Health and Human Services (HHS) Secretary Tom Price, M.D., Acting Assistant Attorney General Kenneth A. Blanco of the Justice Department's Criminal Division, Acting FBI Director Andrew McCabe, Acting Drug Enforcement Administration (DEA) Administrator Chuck Rosenberg, Inspector General Daniel Levinson of the HHS Office of Inspector General (OIG), IRS-Criminal Investigations Chief Don Fort, Centers for Medicare and Medicaid Services Administrator Seema Verma, and Deputy Director Kelly P. Mayo of the Defense Criminal Investigative Service (DCIS).

“As alleged, the defendants charged in the Eastern District of New York as part of this national takedown took advantage of programs designed to provide essential healthcare for the elderly and the needy. Doctors, medical professionals and others who defraud Medicare and Medicaid and pay illegal kickbacks to line their pockets at the taxpayers’ expense are on notice that they will be investigated and prosecuted,” stated Acting United States Attorney Rohde. Ms. Rohde extended her grateful appreciation to the U.S. Office of Personnel Management, Office of Inspector General (OPM-OIG), U.S. Immigration and Customs Enforcement, Homeland Security Investigations (HSI), the Drug Enforcement Administration (DEA), the New York City Police Department (NYPD), the New York Attorney General’s Medicaid Fraud Control Unit (MFCU), the New York City Human Resources Administration and the New York City Health and Hospitals Corporation, Office of Inspector General, for their assistance in the investigations in this district.

“Bhambhani’s alleged acts of illegally paying for patient referrals and submitting a plethora of false million-dollar claims to Medicare and Medicaid were aimed towards selfish gain,” FBI Assistant Director-in-Charge Sweeney Jr. stated. “Crimes of this nature not only stand to compromise government programs created to assist those in need, but also the confidence of those who put great trust in doctors and medical professionals. It goes without saying that to betray this trust is utterly unethical.”

“Being a health care provider in the Medicare and Medicaid programs is a privilege, not a right. When fraudsters rip off scarce taxpayer funds meant to pay for legitimate health care services, they undermine these vital programs and affect the millions of Americans who rely on them,” said Special Agent in Charge Lampert of HHS-OIG. "Our agency, working closely with our law enforcement partners, will continue root out fraudulent schemes and hold criminals accountable in order to protect the integrity of our nation’s federally funded health care system.”

“Healthcare Fraud is not a victimless crime,” stated IRS-Criminal Investigation Special Agent-in-Charge Robnett. “We all pay when others swindle the United States overnment. With both law enforcement and financial investigation expertise, our agents are uniquely qualified to assist our law enforcement partners in these cases, by following the money when investigating these allegations.”

“Individuals who commit Medicaid fraud prey on the most vulnerable New Yorkers, and the impacts - fewer health care resources and waste of taxpayer dollars - affect all of us,” said OMIG Inspector General Rosen. “My office will continue to work closely with our partners at the federal and state level to root out fraud and hold wrongdoers fully accountable.”

The schemes charged in the Eastern District of New York, detailed in four indictments and two criminal complaints, are as follows:

> Ghanshyam Bhambhani: A criminal complaint charges Ghanshyam Bhambhani, a Queens cardiologist, with violating the Anti-Kickback Statute by paying other physicians for patient referrals to his practice. A search warrant was also executed at his medical office in Ozone Park. According to the complaint, physicians who worked with the doctor covertly recorded him discussing paying for patient referrals. Bhambhani, along with other employees of his practice, submitted over $3.7 million in claims to Medicare Part B, and Bhambhani is listed

as the attending physician for over $7.4 million in claims submitted to Medicare Part A. This case is being prosecuted by Assistant United States Attorney Erin Argo and Senior Litigation Counsel Patricia Notopoulos of the U.S. Attorney's Office for the Eastern District of New York. Bhambani was arrested today and he is expected to be arraigned this afternoon before United States Magistrate Judge Robert Levy at the federal courthouse in Brooklyn, New York on July 13, 2017.

United States v. Wael Bakry, et al.: The indictment charges five health care professionals for their role in a wide-ranging health care fraud conspiracy in Brooklyn and Queens that billed the Medicare program approximately $100 million. The defendants—Wael Bakry, a physical therapist, Abraham Demoz, a physician, Victor Genkin, an occupational therapist, Mayura Kanekar, an occupational therapist, and Alexander Khavash, a chiropractor—were charged with conspiring to commit health care and wire fraud and with related tax charges. According to the indictment, the defendants paid illegal kickbacks for the referral of patients to their clinics who, in turn, subjected themselves to purported physical and occupational therapy and other services. This case is being prosecuted by Acting Assistant Chief A. Brendan Stewart and Trial Attorney Richard A. Powers of the Criminal Division's Fraud Section. Bakry, Demoz, and Kanekar were arrested and arraigned before States Magistrate Judge Vera M. Scanlon at the federal courthouse in Brooklyn, New York on July 10, 2017. The case has been assigned to States District Judge Pamela K. Chen.

Xiaoliang Zhang: A criminal complaint charges Xiaoliang Zhang, a licensed physician specializing in rehabilitation medicine, with health care fraud for submitting $27 million worth of claims to Medicare and Medicaid for physical therapy services even though such services were not medically necessary, often not provided, and otherwise did not qualify for reimbursement. Search warrants were executed by agents from the FBI and HHS-OIG at two of Zhang's medical clinic locations, which he operated under the name Elmhurst United Medical, P.C. As described in the complaint, Zhang ordered his physical therapists to bill Medicare and Medicaid for administering treatments to patients that were not rendered. This case is being prosecuted by Senior Litigation Counsel Patricia Notopoulos of the U.S. Attorney's Office for the Eastern District of New York. Zhang was arrested and arraigned before United States Magistrate Judge Robert M. Levy at the federal courthouse in Brooklyn, New York on July 12, 2017.

Svetlana Shargorodskaya: The indictment charges Svetlana Shargorodskaya, the owner of a medical diagnostic testing company, LUVR Diagnostic Services, with health care fraud, false claims, and conspiracy to receive and pay kickbacks. As set forth in the indictment, Shargorodskaya, through LUVR, submitted false claims to various health care benefit programs, including Medicare, and paid patients to receive medically unnecessary services. LUVR fraudulently billed Medicare and insurance companies for more than $13 million in diagnostic testing services. This case is being prosecuted by Trial Attorneys Debra Jaroslawicz and Richard A. Powers of the Criminal Division's Fraud Section. Shargorodskaya was

arrested and arraigned before United States Magistrate Judge Robert M. Levy at the federal courthouse in Brooklyn, New York on July 12, 2017. The case has been assigned to United States District Judge Margo K. Brodie.

Suzanna Meliksetyan: The indictment charges Suzanna Meliksetyan with conspiracy to commit health care fraud, health care fraud, and false statements relating to health care matters for her role in a scheme to defraud Healthfirst, a non-profit, New York-based health maintenance organization that administered Medicare Advantage plans and New York Medicaid Managed Care plans for participating members. As described in the indictment, Meliksetyan and others impersonated representatives of approved providers in order to get approval for the submission of fraudulent claims for durable medical equipment. In total, the scheme resulted in the submission of more than $12 million in fraudulent claims and the payment of more than $5 million for those claims. This case is being prosecuted by Trial Attorney Andrew Estes of the Criminal Division's Fraud Section. Meliksetyan was arrested and arraigned before United States Magistrate Judge Timothy J. Sullivan at the federal courthouse in Greenbelt, Maryland on July 11, 2017. The case has been assigned to United States District Judge Roslynn R. Mauskopf.

Vadim Alekseyev: The indictment charges Vadim Alekseyev, who owned and operated a number of shell companies in furtherance of a health care fraud and kickback scheme, with conspiracy to commit money laundering and conspiracy to obstruct the lawful functions of the Internal Revenue Service. As described in the indictment, Alekseyev and his co-conspirators filled multiple Brooklyn-area clinics, which purported to provide physical and occupational therapy to Medicare and Medicaid beneficiaries, with patients by paying bribes and kickbacks to beneficiaries and to Brooklyn-area ambulance drivers, who provided patients to be subjected to medically unnecessary treatment at the clinics. Through the clinics in which Alekseyev was involved, he and his co-conspirators submitted claims for over $40 million in purported therapy sessions in return for which Medicare and Medicare paid the clinics over $11 million. This case is being prosecuted by Trial Attorneys Sarah Wilson and Richard A. Powers of the Criminal Division's Fraud Section.

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

The Defendants:

Ghanshyam Bhambhani
Age: 52
Queens, NY

EDNY Docket No. 17-M-604

WAEL BAKRY

Age: 45
Staten Island, NY

Dr. Abraham Demoz
Age: 57
Oceanside, NY

Victor Genkin
Age: 48
Brooklyn, NY

Mayura Kanekar
Age: 42
Bayside, NY

Alexander Khavash
Age: 40
Parkland, FL

EDNY Docket No. 17-CR-353

XIAOLIANG ZHANG
Age: 53
Brooklyn, NY

EDNY Docket No. 17-M-618

Svetlana Shargorodskaya
Age: 47
Staten Island, NY

EDNY Docket No. 17-CR-358

Suzanna Meliksetyan
Age: 28
Montgomery Village, MD

EDNY Docket No. 17-CR-351

Vadim Alekseyev
Age: 33
Brooklyn, NY

EDNY Docket No. 17-CR-336

Topic(s):

Health Care Fraud
StopFraud

Component(s):
Federal Bureau of Investigation (FBI)
USAO - New York, Eastern

Contact:
John
Marzulli Tyler Daniels United States Attorney’s Office (718) 254-6323

Updated July 13, 2017

JUSTICE NEWS

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 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.

Attachment(s):
Download National Healthcare Fraud Takedown

Topic(s):
False Claims Act
Health Care Fraud
StopFraud

Component(s):
Criminal Division
Criminal - Criminal Fraud Section
Office of the Attorney General

Press Release Number:
16-725

Updated April 27, 2017

JUSTICE NEWS

Attorney General Loretta E. Lynch Delivers Remarks at Press Conference Announcing a National Healthcare Fraud Takedown

Washington, DC ~ Wednesday, June 22, 2016

Remarks as prepared for delivery

Good morning everyone and thank you all for being here. I am joined by several key leaders in our nation's efforts to address health care fraud: Department of Health and Human Services Secretary [Sylvia] Burwell; Assistant Attorney General for the Criminal Division [Leslie] Caldwell; United States Attorney [Wifredo] Ferrer of the Southern District of Florida; FBI Associate Deputy Director [David] Bowdich; HHS Deputy Inspector General for Investigations [Gary] Cantrell; DCIS Acting Director [Dermot] O'Reilly; and [Shantanu] Agrawal, Deputy Administrator and Director of the Center for Program Integrity at the Centers for Medicare and Medicaid Services.

We are here today to announce a significant step in the federal government's ongoing work to keep our nation's health care system free of fraud and exploitation and to ensure that taxpayer dollars are used lawfully and appropriately. Over the last three days, the Medicare Fraud Strike Force – a joint effort between the Department of Justice and the Department of Health and Human Services – executed a significant nationwide health care fraud takedown. This action involved charging or unveiling charges against approximately 300 defendants in 36 federal districts for their alleged participation in a variety of schemes involving more than $900 million in fraudulent billings, making this the largest takedown in the Strike Force's nine-year history.

The defendants named in these charges include doctors, nurses, pharmacists, physical therapists and home health care providers. They are accused of a wide range of serious crimes, from conspiring to commit health care fraud to making false statements and from bribery to money laundering. They submitted dishonest claims, charged excessive fees and prescribed unnecessary drugs. One group of defendants controlled a network of clinics in Brooklyn that they filled with patients through bribes and kickbacks. These patients then received medically unnecessary treatment, for which the clinic received over $38 million from Medicare and Medicaid – money that the conspirators subsequently laundered through more than 15 shell companies. In another case, a Detroit clinic billed Medicare for more than $36 million, even though it was actually a front for a narcotics diversion scheme. And yet another defendant took advantage of his position in a state agency in Georgia by accepting bribes and recommending the approval of unqualified health providers. These are just a few examples of the criminals that we targeted in this operation and although the specific nature of their wrongdoing varied from case to case, all of them betrayed the basic principles of their professions.

In addition to the usual patterns of fraud and deception that we've encountered in the past, we also saw new trends emerging in this year's charges. For instance, in a number of cases involving the Medicare prescription drug benefit program known as Part D, we saw new evidence of identity theft, including the use of stolen doctors' IDs to prepare fake prescriptions. We have also seen a growing number of cases involving compounded medications, which are combinations of two or more drugs prepared by a licensed

professional. In recent years, the cost of these drugs has grown exponentially, making them a more attractive target for criminals looking to exploit them for profit.

As this takedown should make clear, health care fraud is not an abstract violation or benign offense. It is a serious crime. 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.

In tackling these challenges, the Medicare Fraud Strike Force relies on close cooperation between the federal, state and local, governments. Since 2014, the Justice Department's Criminal Division has organized an annual National Health Care Fraud Training Conference for Assistant U.S. Attorneys and state and federal law enforcement officers, which has substantially expanded the reach of our actions. More than 20 non-Strike Force U.S. Attorney's Offices participated in this year's takedown, helping us to combat health care fraud in a total of 30 federal districts nationwide, from Alaska to Florida. We were also assisted by approximately 20 state Medicaid Fraud Control Units, a reflection of the close partnership between state and federal authorities in combatting health care fraud – a partnership that we will continue to strengthen in the days ahead.

I want to thank my colleagues in the FBI, the Criminal Division and U.S. Attorneys' Offices for their ongoing efforts to combat health care fraud. I want to thank all of the state and local law enforcement officers across the country who participated in this complex and fast-moving takedown. And I look forward to continuing our work together in the days ahead.

At this time, I'd like to turn things over to Secretary Burwell, who has been a dedicated leader and indispensable partner in this critical work and who will provide additional details on today's announcement.

Speaker:
Attorney General Loretta E. Lynch

Topic(s):
Health Care Fraud

Component(s):
Office of the Attorney General

Updated September 29, 2016

JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE   Friday, September 15, 2017

Owner of Two New York Medical Clinics Sentenced to 84 Months for Her Role in $55 Million Health Care Fraud Scheme

The owner of two Brooklyn, New York, medical clinics was sentenced today to 84 months in prison for her role in a $55 million health care fraud scheme.

Acting Assistant Attorney General Kenneth A. Blanco of the Justice Department's Criminal Division, Acting U.S. Attorney Bridget M. Rohde of the Eastern District of New York, Special Agent in Charge Scott Lampert of the U.S. Department of Health and Human Services Office of Inspector General's (HHS OIG) Office of Investigations, Special Agent in Charge James D. Robnett of the IRS Criminal Investigation's (IRS-CI) New York Field Office and Inspector General Dennis Rosen of the New York State Office of the Medicaid Inspector General (OMIG) made the announcement.

Valentina Kovalienko, 47, of Brooklyn, and the owner of Prime Care on the Bay LLC and Bensonhurst Mega Medical Care P.C., was sentenced by U.S. District Judge Roslynn R. Mauskopf of the Eastern District of New York, who also ordered Kovalienko to forfeit $29,336,497. Kovalienko pleaded guilty in October 2015 to one count of conspiracy to commit health care fraud and one count of conspiracy to commit money laundering.

As part of her guilty plea, Kovalienko acknowledged that her co-conspirators paid cash kickbacks to patients to induce them to attend her two clinics. Kovalienko also admitted that she submitted false and fraudulent claims to Medicare and Medicaid for services that were induced by prohibited kickback payments to patients or that were unlawfully rendered by unlicensed staff. Kovalienko also wrote checks from the clinics' bank accounts to third-party companies, which purported to provide services to the clinics, but which in fact were not providing services, and the payments were instead used to generate the cash needed to pay the illegal kickbacks to patients, she admitted.

Twenty other individuals have pleaded guilty in connection with this case, including the former medical directors of Prime Care on the Bay LLC and Bensonhurst Mega Medical Care P.C., six physical and occupational therapists, three ambulette drivers, the owner of several of the sham companies used to launder the money and a former patient who received illegal kickbacks.

HHS-OIG, IRS-CI and OMIG investigated the case, which was brought as part of the Medicare Fraud Strike Force, under the supervision by the Criminal Division's Fraud Section and the U.S. Attorney's Office for the Eastern District of New York. Acting Assistant Chief A. Brendan Stewart of the Fraud Section and Assistant U.S. Attorney F. Turner Buford of the Eastern District of New York, formerly a Fraud Section trial attorney, are prosecuting the case.

The Criminal Division's Fraud Section leads the Medicare Fraud Strike Force. Since its inception in March 2007, the Medicare Fraud Strike Force, now operating in nine cities across the country, has charged nearly 3,500 defendants who have collectively billed the Medicare program for more than $12.5 billion. In addition, the HHS Centers for Medicare & Medicaid Services, working in conjunction with the HHS-OIG, are taking steps to increase accountability and decrease the presence of fraudulent providers.

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

Component(s):
Criminal Division
USAO - New York, Eastern

Press Release Number:
17-1014

Updated September 15, 2017

JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE Tuesday, November 12, 2013

Brooklyn Clinic Owner Sentenced for Role in $77 Million Medicare Fraud Scheme

The owner of a Brooklyn medical clinic was sentenced today to serve 15 years in prison for her leading role in a $77 million Medicare fraud scheme.

Acting Assistant Attorney General Mythili Raman of the Justice Department's Criminal Division, U.S. Attorney for the Eastern District of New York Loretta E. Lynch, Assistant Director in Charge George Venizelos of the FBI's New York Field Office, and Special Agent in Charge Thomas O'Donnell of the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) made the announcement.

Irina Shelikhova, 50, of Brooklyn, was sentenced by U.S. District Judge Nina Gershon of the Eastern District of New York. In addition to her prison term, Shelikhova was sentenced to serve three years of supervised release with a concurrent exclusion from Medicare, Medicaid and all Federal health programs, ordered to forfeit $36,241,545 and ordered to pay $50,943,386 in restitution. Shelikhova has been in custody since her arrest at the John F. Kennedy International Airport on June 15, 2012, after living as a fugitive in Ukraine for nearly two years. After serving her sentence, Shelikhova faces deportation from the United States.

Shelikhova pleaded guilty on Dec. 18, 2012, to one count of conspiracy to commit money laundering. Including Shelikhova, 13 individuals have been convicted in this case.

Court documents state that from 2005 to 2010, Shelikhova owned and operated a clinic in Brooklyn that billed Medicare under three corporate names: Bay Medical Care PC, SVS Wellcare Medical PLLC and SZS Medical Care PLLC (collectively, Bay Medical clinic). Shelikhova and her employees at the Bay Medical clinic paid cash kickbacks to Medicare beneficiaries and used the beneficiaries' names to bill Medicare for more than $77 million in services that were medically unnecessary or never provided. The defendants billed Medicare for a wide variety of fraudulent medical services and procedures, including physician office visits, physical therapy and diagnostic tests.

According to trial testimony, Shelikhova masterminded the health care fraud at the Bay Medical clinic, which included hiring a medically unlicensed co-defendant to impersonate the clinic's doctor and render medical care to patients. Shelikhova also directed employees to create phony medical notes in an attempt to back up the false billing and to forge doctors' names on prescriptions and charts.

The government's investigation included the use of a court-ordered audio/video recording device hidden in a room at the clinic, which showed conspirators paying cash kickbacks to corrupt Medicare beneficiaries. The conspirators were recorded paying approximately $500,000 in cash kickbacks during a period of

approximately six weeks from April to June 2010. This room was marked “PRIVATE” and featured a Soviet-era poster of a woman with a finger to her lips and the words “Don’t Gossip” in Russian. The purpose of the kickbacks was to induce the beneficiaries to receive unnecessary medical services or to stay silent when services not provided to the patients were billed to Medicare.

To generate the large amounts of cash needed to pay the patients, Shelikhova directed the recruitment and operations of a network of external money launderers who cashed checks for the clinic. Shelikhova wrote clinic checks payable to various shell companies controlled by the money launderers. These checks did not represent payment for any legitimate service at or for the Bay Medical clinic, but rather were written to launder the clinic’s fraudulently obtained health care proceeds. The money launderers cashed these checks and provided the cash back to the clinic. Shelikhova used the cash to pay illegal cash kickbacks to the Bay Medical clinic’s purported patients.

The case was investigated by the FBI and HHS-OIG and was brought as part of the Medicare Fraud Strike Force, under the supervision of the Criminal Division’s Fraud Section and the U.S. Attorney’s Office for the Eastern District of New York. This case is being prosecuted by Trial Attorney Sarah M. Hall of the Fraud Section and Assistant U.S. Attorney Shannon Jones of the Eastern District of New York.

Since its inception in March 2007, the Medicare Fraud Strike Force, now operating in nine cities across the country, has charged more than 1,500 defendants who have collectively billed the Medicare program for more than $5 billion. In addition, HHS’s Centers for Medicare & Medicaid Services, working in conjunction with HHS-OIG, is taking steps to increase accountability and decrease the presence of fraudulent providers.

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

Component(s):
Criminal Division

Press Release Number:
13-1207

Updated September 15, 2014