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FOUR CHICAGO AREA DEFENDANTS CHARGED IN NATIONWIDE MEDICARE FRAUD STRIKE FORCE TAKEDOWN; THREE OTHERS CHARGED WITH DEFRAUDING PRIVATE HEALTH INSURERS

Total of 91 Defendants Charged Nationwide for Submitting More Than $295 Million in False Billing to Medicare

CHICAGO — An area vascular surgeon, three chiropractors, a psychologist and a nursing home admissions director are among seven defendants charged this week with participating in four separate, unrelated health care fraud schemes to defraud the Medicare program or private health insurers of millions of dollars, federal law enforcement officials announced today.

Three of the Chicago cases charging four defendants are part of a nationwide takedown by Medicare Fraud Strike Force operations, announced today by the Departments of Justice and Health and Human Services, that led to charges against 91 defendants for their alleged participation in schemes to collectively submit more than $295 million in fraudulent claims to the Medicare program. This coordinated takedown involved the highest amount of false Medicare billings in a single takedown in Strike Force history.

In Chicago, four defendants were charged in a criminal information and two indictments filed today and three defendants were indicted last week in U.S. District Court. The defendants were charged with various crimes, including health care fraud for allegedly defrauding the Medicare

program, and violating the anti-kickback statute, which makes it illegal to offer or solicit kickbacks in exchange for referrals of Medicare patients. The charges involve various medical treatments and services such as surgery, nursing home care, chiropractic and psychotherapy services.

"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 Eric 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," he said.

"Today's action further demonstrates the commitment we announced earlier this year to ensure that dishonest medical providers do not profit from cheating Medicare and private insurers," said Patrick J. Fitzgerald, United States Attorney for the Northern District of Illinois.

Details of the Chicago cases follow:

United States v. John Natale

Dr. John Natale, a vascular surgeon who had privileges at Northwest Community Hospital in Arlington Heights, was charged in a five-count indictment returned today with defrauding Medicare by submitting false claims and by intentionally preparing fictitious medical reports that detailed medical procedures that he knew did not occur or were more complex than those he actually performed.

Natale, 62, of South Barrington, was charged with two counts of health care fraud, two counts of making false statements involving a health care benefit program and one count of mail fraud. He will be arraigned at a later date in U.S. District Court.

Between August 2002 and October 2004, Natale allegedly falsely sought Medicare reimbursement for aneurysm repairs that he never performed, and falsely claimed to have performed more complicated repair of certain aneurysms, or weakened blood vessels, knowing that the

surgeries he had performed involved less complicated procedures. Natale allegedly used the proceeds of the fraudulently obtained Medicare payments for his own personal benefit.

According to the indictment, surgical insertion of a graft above or in the immediate vicinity of the kidneys to repair a supra-renal or juxta-renal aneurysm is generally more complex than the surgical insertion of a graft below the kidneys to repair an infra-renal aneurysm. For at least five patients, Natale also allegedly prepared false medical reports that, among other things, contained extensive details about aneurysm repairs that he never performed, and falsely described the surgeries he did perform as being more complex and elaborate than they actually were.

The government is represented by Assistant U.S. Attorney Amarjeet Bhachu. The case was investigated by the U.S. Postal Inspection Service and the Health and Human Services Office of Inspector General (HHS-OIG.)

United States v. Keenan Ferrell and Bryce Woods

Keenan R. Ferrell, a licensed psychologist in Illinois and at least a half-dozen other states, and **Bryce Woods**, who was not a medical professional in any field, owned and operated Take Action, Inc., and Inner Arts, Inc., which claimed to provide psychotherapy services to Medicare beneficiaries residing in skilled nursing homes in the Chicago area and elsewhere. Between September 2003 and July 2011, Ferrell and Woods allegedly submitted false claims totaling more than $4.4 million to Medicare for psychotherapy services, and fraudulently obtained approximately $1,863,415 million.

Ferrell, 51, and Woods, 34, both of Chicago, were each charged with nine counts of health care fraud in an indictment returned today. The indictment also seeks forfeiture of more than $1.8 million in alleged illegal proceeds. They will be arraigned at a later date in U.S. District Court.

According to the indictment, Ferrell and Woods submitted false claims to Medicare on behalf of patients living in skilled nursing homes under a Medicare provider number belonging to Ferrell claiming that he had provided 45-50 minutes of one-on-one psychotherapy to patients, when in fact, the treatment sessions were done by Woods, psychology graduate students recruited by Ferrell, or others with limited or no physician supervision.

Knowing that psychotherapy services were reimbursable by Medicare only when performed by an enrolled provider or when "incident to" the services of an enrolled provider, Ferrell and Woods allegedly arranged for Ferrell, who was an enrolled Medicare provider and licensed medical doctor, to authorize Inner Arts and Take Action to accept assignment of his claims to Medicare. Ferrell and Woods allegedly arranged with psychology graduate students and others to see patients at various skilled nursing facilities.

Ferrell, knowing that he needed to be present at nursing homes whenever a therapist conducted a session for Ferrell to be entitled to bill Medicare for services "incident to" his care, did not attend or otherwise participate in therapy sessions in the nursing homes, according to the

indictment. As a result, Ferrell was not physically present and immediately available when Take Action and Inner Arts therapists purportedly were in nursing homes to render psychotherapy services, it adds.

As part of the scheme, Ferrell and Woods allegedly billed Medicare for more psychotherapy sessions than had actually been performed, regardless of the reimbursement code that was used. The indictment also alleges that they billed for services provided to deceased individuals.

The government is represented by Assistant U.S. Attorney Paul Tzur. The case was investigated by the FBI and the HHS-OIG.

United States v. Bradley Mattson, Steven Paul and Neelesh Patel

Three chiropractors, **Bradley Mattson**, **Steven Paul** and **Neelesh Patel**, who owned suburban clinics that provided chiropractic, medical and physical therapy services, were charged in a 23-count indictment with defrauding three private health insurance companies for more than a decade beginning in 1999. Mattson, Paul and Patel owned and operated Hawthorn Physical medicine in Vernon Hills, Woodfield Physical Medicine in Schaumburg, Stratford Physical Medicine in Bloomingdale, and Algonquin Physical Medicine in Lake-in-The-Hills, while Mattson and Paul also owned and operated Northshore Physical Medicine in Niles and Cumberland Physical Medicine in Norridge.

Mattson, 49, of Lake Forest, was charged with 19 counts of health care fraud; Paul, 40, of Northbrook, was charged with four counts of health care fraud; and Patel, 36, of Glenview, was charged with 15 counts of health care fraud. Mattson is scheduled to be arraigned next Tuesday and Paul and Patel are scheduled to be arraigned next Wednesday in U.S. District Court in Chicago.

According to the indictment, the defendants submitted false insurance claims to Blue Cross and Blue Shield of Illinois, Aetna and Humana for services that either were not medically necessary or that they did not provide to patients, including x-rays, MRIs, neurological diagnostic testing, and physical therapy services. Between 1999 and 2008, the defendants billed Blue Cross alone more than $18 million. The indictment does not specify the amount of the allegedly fraudulent claims or the amount that was fraudulently obtained from any of the three insurance carriers.

The defendants allegedly marketed the clinics through their company, ARC Health, at malls and employee health fairs that targeted individuals insured by certain health care benefit programs. They instructed ARC Health marketing employees to offer potential patients coupons that falsely advertised a free x-ray exam and a discounted office visit, which they actually later billed to the patients' insurance companies, the indictment alleges. As part of the fraud scheme, the defendants allegedly instructed their clinics' chiropractors to order neurological diagnostic testing and MRIs for patients, regardless of medical necessity, and then to falsify the patients' diagnoses so their health plans would cover additional visits for treatment.

Mattson alone allegedly received kickbacks from unnamed Individual A, who owned an unnamed MRI facility, in exchange for Mattson sending patients from the six clinics to Individual A's facility for MRI exams.

The government is represented by Assistant U.S. Attorney Renai Rodney. The case was investigated by the FBI and the U.S. Department of Labor Office of Inspector General.

United States v. Jay Canastra

Jay Canastra, the director of admissions at The Wealshire, a nursing home in northwest suburban Lincolnshire, was charged with accepting a $1,600 kickback in exchange for referring nursing home Medicare patients to a home health care agency in West Dundee.

Canastra, 38, of Vernon Hills, was charged with one count of violating the anti-kickback statute in a criminal information filed today in U.S. District Court. He will be arraigned at a later date.

According to the charge, on Dec. 4, 2009, Canastra received the $1,600 cash kickback from unnamed Individual A, who was a representative of unnamed Agency A, which was authorized by Medicare to provide home heath services. Canastra allegedly accepted the payment in exchange for referring Medicare beneficiaries at his nursing home to Agency A, in violation of the federal law that makes it illegal to exchange kickbacks in return for Medicare referrals. There is no allegation that the nursing home or any other official there were aware of the alleged kickback.

The government is represented by Assistant U.S. Attorney Dylan Smith. The case was investigated by the FBI and the HHS-OIG.

The charges in these cases carry the following maximum penalties on each count: health care fraud — 10 years in prison, and mail fraud — 20 years in prison, and both carry a $250,000 maximum fine, or an alternate fine totaling twice the loss or twice the gain, whichever is greater; and making false statements regarding a health care matter, and violating the anti-kickback statute — 5 years in prison and a $250,000 fine. If convicted, the Court must impose a reasonable sentence under the advisory United States Sentencing Guidelines.

The Medicare Fraud Strike Force operations, which expanded to Chicago in February 2011, 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 results of the nationwide takedown were announced today by Attorney General Holder, HHS Secretary Kathleen Sebelius, FBI Director Robert S. Mueller, Assistant Attorney General Lanny A. Breuer of the Criminal Division and Inspector General Daniel R. Levinson of the HHS-OIG. Mr. Fitzgerald announced the Chicago charges together with Robert D. Grant, Special Agent-in-Charge of the Chicago Office of the Federal Bureau of Investigation; Lamont Pugh III, Special Agent-in-Charge of the Chicago Regional Office of the HHS-OIG, James Vanderberg, Special Agent-in-Charge of the Labor Department Office of Inspector General in Chicago; and Thomas P. Brady, Inspector-in-Charge of the Chicago Office of the U.S. Postal Inspection Service.

The public is reminded that indictments and informations contain only charges and are not evidence of guilt. The defendants are presumed innocent and are entitled to a fair trial at which the government has the burden of proving guilt beyond a reasonable doubt.

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

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