Department of Justice

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NATIONAL HEALTHCARE FRAUD TAKEDOWN RESULTS IN CHARGES AGAINST 601 INDIVIDUALS RESPONSIBLE FOR MORE THAN $2 BILLION IN FRAUD LOSSES

Largest Health Care Fraud Enforcement Action in Department of Justice History Resulted in 76 Doctors Charged and 84 Opioid Cases Involving More Than 13 Million Illegal Dosages of Opioids

WASHINGTON - Attorney General Jeff Sessions and Department of Health and Human Services (HHS) Secretary Alex M. Azar III, announced yesterday the largest ever health care fraud enforcement action involving 601 charged defendants across 58 federal districts, including 165 doctors, nurses and other licensed medical professionals, for their alleged participation in health care fraud schemes involving more than $2 billion in false billings. Of those charged, 162 defendants, including 76 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 announced today that from July 2017 to the present, it has excluded 2,700 individuals from participation in Medicare, Medicaid, and all other Federal health care programs, which includes 587 providers excluded for conduct related to opioid diversion and abuse.

Attorney General Sessions and Secretary Azar were joined in the announcement by Acting Assistant Attorney General John P. Cronan of the Justice Department's Criminal Division, Deputy Director David L. Bowdich of the FBI, Assistant Administrator John Martin of the Drug Enforcement Administration (DEA), Inspector General Daniel R. Levinson of the HHS Office of Inspector General (OIG), Deputy Chief Eric Hylton of IRS Criminal Investigation (CI), Director Alec Alexander of the Centers for Medicare and Medicaid Services (CMS) Center for Program Integrity and Director Dermot F. O'Reilly of the Defense Criminal Investigative Service (DCIS).

Yesterday'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, IRS-CI, Department of Labor, other various federal law enforcement agencies, and State Medicaid Fraud Control Units.

The charges announced yesterday aggressively target schemes billing Medicare, Medicaid, TRICARE (a health insurance program for members and veterans of the armed forces and their families), and private insurance companies 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 115 Americans die every day of an opioid-related overdose.

"Health care fraud is a betrayal of vulnerable patients, and often it is theft from the taxpayer," said Attorney General Sessions. "In many cases, doctors, nurses, and pharmacists take advantage of people suffering from drug addiction in order to line their pockets. These are despicable crimes. That's why this Department of Justice has taken historic new steps to go after fraudsters, including hiring more prosecutors and leveraging the power of data analytics. Today the Department of Justice is announcing the largest health care fraud enforcement action in American history. This is the most fraud, the most defendants, and the most doctors ever charged in a single operation—and we have evidence that our ongoing work has stopped or prevented billions of dollars' worth of fraud. I want to thank our fabulous partners with the FBI, DEA, our Health Care Fraud task forces, HHS, the Defense Criminal Investigative Service, IRS Criminal Investigation, Medicare, and especially the more than 1,000 federal, state, local, and tribal law enforcement officers from across America who made this possible. By every measure we are more effective at finding and prosecuting medical fraud than ever."

"Every dollar recovered in this year's operation represents not just a taxpayer's hard-earned money—it's a dollar that can go toward providing healthcare for Americans in need," said HHS Secretary Azar. "This year's Takedown Day is a significant accomplishment for the American people, and every public servant involved should be proud of their work."

According to court documents, the defendants allegedly participated in schemes to submit claims to Medicare, Medicaid, TRICARE, and private insurance companies 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. Collectively, the doctors, nurses, licensed medical professionals, health care company owners and others charged are accused of submitting a total of over $2 billion in fraudulent billings. 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.

Cases that have been indicted in the Eastern District of Kentucky are:

- ***United States v. Kimberly Jones*** **(6:18-cr-00030 E.D. Ky.)**: Kimberly Jones, a licensed pharmacist in Williamsburg, Kentucky, is charged with 26 counts of distributing oxycodone or oxymorphone, one count of maintaining a drug involved premises, and one count of health care fraud. The Indictment alleges that Jones, the owner of Kim's Hometown Pharmacy in Williamsburg, repeatedly filled prescriptions for oxycodone and oxymorphone outside the scope of professional practice, while also billing insurers for prescription drugs that were never dispensed to patients. The Indictment was unsealed following Jones's arrest on June 26, 2018. The case is assigned to United States District Judge Gregory F. Van Tatenhove and is set for trial on August 21, 2018. Jones faces a maximum sentence of 20 years imprisonment if convicted on the controlled substance offenses and 10 years if convicted of health care fraud.

- ***United States v. Gary McPherson*** **(6:18-cr-00031 E.D. Ky.)**: Gary McPherson, a licensed pharmacist, is charged with theft of pre-retail medical products in violation of 18 U.S.C. § 670. The charge stems from McPherson's theft of pharmaceutical drugs from Kim's Hometown Pharmacy in Williamsburg, Kentucky, in May 2018. The Indictment was unsealed on June 26, 2018, and McPherson will appear in court on July 11, 2018, for arraignment. The case is assigned to United States District Judge Gregory F. Van Tatenhove. McPherson faces a maximum sentence of five years imprisonment if convicted.

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 3,700 defendants who collectively have falsely billed the Medicare program for over $14 billion.

A complaint, information, or indictment is merely an allegation, and all defendants are presumed innocent until proven guilty beyond a reasonable doubt in a court of law.

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