National Health Care Fraud Takedown charges more than 400 defendants with $1.3 billion in false billings

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On July 13, 2017, the Department of Health and Human Services (HHS) and Department of Justice (DOJ) announced that 412 defendants across 41 federal districts (including 115 doctors, nurses and other licensed medical professionals) were charged for their participation in health care fraud schemes that accounted for about $1.3 billion in false billings as part of the National Health Care Fraud Takedown. Many of the defendants were charged for prescribing and distributing opioids and other narcotics, signaling increased enforcement by the federal government in the wake of the national opioid epidemic.

The charges brought against the 412 defendants targeted schemes that billed Medicaid, Medicare and TRICARE for prescriptions of medically unnecessary drugs or medications and services that were never distributed or provided to beneficiaries. Attorney General Jeff Sessions signaled that this is likely just the beginning of a major crackdown in the wake of the opioid epidemic, stating "[w]hile 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."

The DOJ press release stated that many of the defendants were patient recruiters, beneficiaries and other co-conspirators who were allegedly paid cash kickbacks in return for supplying beneficiary information to providers, which then allowed the providers to submit fraudulent bills for services that were medically unnecessary or never performed. In addition, over 120 defendants, including doctors, were charged for their roles in prescribing and distributing opioids and other dangerous narcotics.

The United States Attorney's Office for the Southern District of Ohio announced that two Ohio companies and their owners were among the defendants charged as part of the National Health Care Fraud Takedown. One of the indictments alleged that the Ohio Institute of Cardiac Care and Accubil (a billing company) received more than $2 million from Medicare and Medicaid for medically unnecessary nuclear stress tests and medically unnecessary coronary interventions such as pacemaker insertion and stent procedures. The other indictment alleged that Health & Wellness Pharmacy and Health & Wellness Medical Center, both in Dublin, fraudulently received more than $3 million from the Ohio Department of Medicaid and Medicaid Managed Care Organizations (MCOs) through multiple schemes, including billing for compound pain and scar creams that were not provided or not requested by patients, billing for drug treatment and counseling services that were not provided, or billing for group counseling sessions as individual counseling services.

In addition to the criminal charges filed as part of this coordinated enforcement effort, more than 295 individuals (including 57 doctors, 162 nurses and 36 pharmacists) were served with exclusion notices by the HHS Office of Inspector General for conduct related to opioid diversion and abuse. These exclusion notices bar those individuals from participation in or submitting claims to all federal health care programs, including Medicare and Medicaid.

Authors