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22 Defendants Named in Health Care Fraud Cases involving over \$161 Million in Fraudulent Bills to Government Health Care Programs

13 Federal Cases Brought as Part of National Health Care Fraud Sweep Allege Wide Range of Fraud and more than \$125 Million in Losses

LOS ANGELES – Culminating investigations by a host of state and federal law enforcement agencies, federal prosecutors have brought 13 criminal cases that charge a total of 22 defendants in health care fraud schemes. Several medical professionals were charged as part of the sweep, including five physicians, a psychiatrist, one pharmacist and an occupational therapist. The cases announced today allege various schemes that led to more than \$161 million in fraudulent bills being submitted to publicly funded health care programs such as Medicare and TRICARE.

The cases filed in federal court in Los Angeles and Santa Ana are part of a nationwide sweep announced today in Washington by Attorney General Loretta Lynch, who said criminal and civil charges have been filed against 301 individuals who allegedly participated in health care fraud schemes involving approximately \$900 million in false billings. The local cases were filed by Assistant United States Attorneys and Trial Attorneys with the Justice Department's Medicare Fraud Strike Force.

"Health care fraud is a serious offense that costs Americans billions of dollars, and the cases announced today here in Los Angeles alone cost taxpayers more than \$100 million," said United States Attorney Eileen M. Decker. "These crimes affect real people and erode the trust that should exist between a patient and their health care provider. The entire Justice Department and our law enforcement partners are committed and determined to doing everything it takes to ensure the health care system works for the American public – and not those, whether health care providers or others, who seek to abuse the system."

The cases filed in the Southland involve actual losses of more than \$125 million, with the bulk of those losses associated with five cases related to schemes involving compounding pharmacies. In schemes orchestrated by marketers (sometimes called "cappers"), compounding pharmacies were provided with large numbers of prescriptions, generally for pain medications, that carried huge reimbursements, often more than \$15,000 for each prescription. The prescriptions were written by doctors who received kickbacks from marketers or from "telemedicine" websites that had little or no contact with patients. The prescriptions were written for "patients" who, in many cases, did not want the prescriptions, had never met the prescribing

doctors or had no idea why they were receiving the medications. In many cases, the beneficiary information was being used without the knowledge of the “patients” until the prescriptions showed up at their homes.

TRICARE, the military’s managed care program, was the primary victim of schemes involving the compounding pharmacies. Over the course of just a few years, TRICARE paid hundreds of millions of dollars for medications dispensed to “patients” across the nation, typically creams that supposedly would treat minor pain, scars, erectile dysfunction or “general wellness.” Five of the cases announced today relate to compounding pharmacies and allege losses of more than \$100 million, most of which was paid by TRICARE over the course of just a few months.

In one case, John Garbino, a marketer who resides in Dana Point, was charged with receiving illegal kickbacks after referring prescriptions to compounding pharmacies that filled the prescriptions and billed TRICARE. One Palmdale pharmacy allegedly received more than \$46 million from TRICARE in only six months. Another pharmacy in Corona received nearly \$6 million over the same six-month period. Garbino allegedly received illegal kickbacks of as much as 65 percent for referring prescriptions to the compounding pharmacies. The criminal complaint against Garbino alleges that one of the pharmacies dramatically increased its claims to TRICARE “for filling compounded medications prescriptions that had been specially formulated to achieve the highest possible reimbursement rates rather than the greatest medical efficacy.”

In another scheme, the Florida-based operator of a “telemedicine” website was charged with health care fraud for allegedly misusing the identity and medical credentials of a physician to submit prescriptions to a compounding pharmacy. The criminal complaint in this case alleges that two local pharmacies received more than \$6.5 million in payments from TRICARE in 2015.

In a third case, the owner of a La Mirada pharmacy, two marketers and a doctor were indicted on charges of paying and receiving illegal kickbacks. Health insurers paid the pharmacy, Valley View Drugs, more than \$20 million, and the pharmacy paid nearly half of that to companies associated with the marketers.

“The Defense Criminal Investigative Service, 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 Special Agent in Charge Chris Hendrickson, DCIS Western Field Office. “Their actions threaten to cripple our vital national health care industry, and place our citizenry at risk. Over \$100 million in Department of Defense health care funds that should have been used to treat the military and their families was instead allegedly stolen by swindlers. We will remain vigilant.”

“These arrests demonstrate that the U.S. Government will not tolerate fraud in the compounding pharmacy industry,” said Norbert E. Vint, the Acting Inspector General for the Office of Personnel Management, Office of Inspector General. “We appreciate the efforts of all the investigating agencies and the Department of Justice that have held these individuals accountable for their actions, and thereby protected taxpayer funded health care programs, including the Federal Employees Health Benefits Program.”

“The United States Postal Service, Office of Inspector General, along with our law enforcement partners will aggressively investigate those who engage in fraudulent activities intended to defraud federal benefit programs and the Postal Service,” said Special Agent in Charge Brian Washington, U.S. Postal Service, Office of Inspector General. “This week’s arrests should send a clear message to all health care providers that health care fraud is a federal crime that carries serious consequences and will not be tolerated.”

“Patients were pawns in an alleged pay-for-play fraud scheme,” said California Insurance Commissioner Dave Jones. “Patients should be able to trust that medications prescribed for them are based on their healthcare needs, not on payoffs and kickbacks to physicians and pharmacists.”

In other cases announced today, a doctor who had offices in Temecula and Mira Loma allegedly submitted nearly \$12 million in fraudulent bills to Medicare for unnecessary “vein ablation” surgery. Another doctor was charged for helping the owner of a Granada Hills medical clinic, who recruited Medicare patients with promises of free equipment and used their beneficiary information to bill for services that simply were never provided.

“Medical professionals who seek to enrich themselves through Medicare fraud – such as exchanging illegal kickbacks or billing for medically unnecessary procedures – undermine this taxpayer-funded program and drive up health care costs for everyone,” said Special Agent in Charge Chris Schrank, of the U.S. Department of Health and Human Services, Office of Inspector General. “Today’s announcement shows our commitment to working with our state and federal law enforcement partners to swiftly investigate such allegations of fraud.”

Another case announced today charges three defendants in a scheme to defraud the health benefit plans established for members of the International Longshore and Warehouse Union and Federal Express employees. Participants in the scheme allegedly paid beneficiaries of those plans to undergo unnecessary sleep and nerve conduction velocity studies that were then billed to the plans. The defendants operated facilities in Sherman Oaks and San Pedro, where the testing was conducted as part of the fraud scheme that submitted at least \$16 million in bills to the union and FedEx health plans. The defendants in this case also face money laundering charges.

“Those who commit fraud targeting health care funding get rich on the backs of American taxpayers who watch their premiums go up,” said Deirdre Fike, Assistant Director in Charge of the FBI’s Los Angeles Field Office. “Anyone who identifies suspicious billing practices or unlawful activity by a provider should contact a member of the Strike Force.”

“In the coming years, we will continue to leverage our financial skill set and focus on investigating those whose criminal activity drives up medical costs and jeopardizes a system that our citizens have come to trust,” stated IRS Criminal Investigation’s Acting Special Agent in Charge Anthony J. Orlando. “We will continue to work with our federal and state law enforcement partners to bring to justice those individuals who prey on the nation’s health care system for their own personal greed.”

Most of the 22 defendants named in the cases were arrested on Monday and Tuesday. Several defendants self-surrendered after learning of the federal charges. A separate announcement details all 13 cases and the defendants charged in those cases.

Indictments and criminal information contain allegations that a defendant has committed a crime. Every defendant is presumed to be innocent until and unless proven guilty in court.

The cases announced this week in Los Angeles are the result of investigations conducted by the United States Department of Health and Human Services, Office of Inspector General; the Defense Criminal Investigative Service; the Federal Bureau of Investigation; the Office of Personnel Management, Office of Inspector General; the Veterans Administration, Office of the Inspector General; the Department of Labor, Employee Benefits Security Administration; the California Department of Insurance, Fraud Division; the United States Postal Service, Office of the Inspector General; Amtrak’s Office of the Inspector General; the California Board of Pharmacy; IRS Criminal Investigation; and the California Department of Justice.

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