JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE Thursday, September 26, 2019

Federal Health Care Fraud Takedown in Northeastern U.S. Results in Charges Against 48 Individuals

Three Plead Guilty to One of Largest Health Care Fraud Schemes Prosecuted Involving Fraudulent Telemedicine Networks Targeting Elderly Patients Nationwide

The Justice Department today announced a coordinated health care fraud enforcement action across seven federal districts in the Northeastern United States, involving more than $800 million in loss and the distribution of over 3.25 million pills of opioids in "pill mill" clinics. The takedown includes new charges against 48 defendants for their roles in submitting over $160 million in fraudulent claims, including charges against 15 doctors or medical professionals, and 24 who were charged for their roles in diverting opioids.

In addition to the new charges, today's enforcement action also includes the guilty pleas of three corporate executives, including the Vice President of Marketing of numerous telemedicine companies and two owners of approximately 25 durable medical equipment companies, for their roles in causing the submission of over $600 million in fraudulent claims to Medicare. This is one of the largest health care fraud schemes ever investigated by the FBI and the U.S. Department of Health and Human Services Office of the Inspector General (HHS-OIG) and prosecuted by the Department of Justice, which previously resulted in charges against 21 other defendants. The enforcement action also includes three additional recent guilty pleas by other defendants. In addition, the Centers for Medicare & Medicaid Services, Center for Program Integrity (CMS/CPI) announced today that all appropriate administrative actions would be taken based on these charges. As part of the announcement in April, CMS/CPI announced that it took administrative action against 130 DME companies that submitted over $1.7 billion in claims to the Medicare program.

Today's enforcement actions were led and coordinated by the Health Care Fraud Unit of the Criminal Division's Fraud Section in conjunction with its Medicare Fraud Strike Force (MFSF), as well as the U.S. Attorney's Offices for the District of New Jersey, Eastern District of Pennsylvania, Western District of Pennsylvania, Eastern District of New York, Western District of New York, District of Connecticut and District of Columbia. The MFSF is a partnership among the Criminal Division, U.S. Attorney's Offices, the FBI and HHS-OIG. In addition, IRS-Criminal Investigations (IRS-CI), Department of Defense-Defense Criminal Investigative (DoD-DCIS), Food and Drug Administration-Office of Inspector General (FDA-OIG), U.S. Postal Service-Office of Inspector General (USPS-OIG), the Medicaid Fraud Control Unit and other federal and state law enforcement agencies participated in the operation.

The charges and guilty pleas announced today continue to target corporate health care fraud involving fraudulent telemedicine companies and the solicitation of illegal kickbacks and bribes from health care suppliers in exchange for the referral of Medicare beneficiaries for medically unnecessary durable medical equipment and other testing. The charges also involve individuals contributing to the opioid epidemic, including medical professionals involved in the unlawful distribution of opioids and other prescription narcotics, a particular focus for the Department. According to the Centers for Disease Control, approximately 115 Americans die every day of an opioid-related overdose.

Today's arrests and guilty pleas come one-year after the Department of Justice announced the formation of the Newark/Philadelphia Regional Medicare Fraud Strike Force, a joint law enforcement effort that brings together the resources and expertise of the Health Care Fraud Unit in the Criminal Division's Fraud Section, the U.S. Attorney's Offices for the District of New Jersey and the Eastern District of Pennsylvania, as well as law enforcement partners.

The Strike Force focuses its efforts on aggressively investigating and prosecuting complex cases involving patient harm, large financial loss to the public fisc, and the illegal prescribing and distribution of opioids and other dangerous narcotics.

“Physicians and other medical professionals who fraudulently bill our federal health care programs are stealing from taxpayers and robbing vulnerable patients of necessary medical care. The medical professionals and others engaging in criminal behavior by peddling opioids for profit continue to fuel our nation’s drug crisis,” said Assistant Attorney General Brian A. Benczkowski of the Justice Department’s Criminal Division. “The Department of Justice will continue to use every tool at our disposal, including data analytics and traditional law enforcement techniques, to investigate, prosecute, and punish this reprehensible behavior and protect federal programs from abuse.”

“As today’s takedown demonstrates, this Strike Force has produced precisely what we hoped it would – and by that I mean tangible results,” said U.S. Attorney William M. McSwain of the Eastern District of Pennsylvania. “We have brought together a wealth of resources, knowledge, and subject-matter expertise – that of health care fraud prosecutors, civil enforcement assistant U.S. attorneys, data analysts, and law enforcement agencies – all working to stop fraud, waste, and abuse within our federal health care programs and to stem the tide of illegal opioid distribution. These are top priorities of the Department of Justice and my Office, and our focus in this area continues to pay off.”

“Under the law, healthcare professionals are obligated to exercise appropriate care and judgment in the manner in which opiates are prescribed and distributed in order to ensure that such substances are, in fact, ‘controlled,’” said U.S. Attorney James P. Kennedy Jr. of the Western District of New York. “When such professionals abandon that obligation and instead engage in acts of fraud and deceit, they will be prosecuted.”

“As alleged, defendants charged in the Eastern District of New York used fraud and deceit to steal Medicaid and Medicare funds meant to protect our elderly and most vulnerable residents,” stated U.S. Attorney Donoghue of the Eastern District of New York. “As this initiative demonstrates, we will continue to bring to justice those that defraud our nation’s health care programs.”

“We continue to work closely with our law enforcement partners to identify, investigate and eliminate fraud, waste and abuse in the nation’s federal healthcare programs,” said Deputy Administrator and CPI Center Director Alec Alexander. “In this case, CMS will take swift administrative action against providers responsible for fraudulent billings to federal healthcare programs. CMS is committed to protecting vulnerable beneficiaries from exploitation and safeguarding taxpayer dollars.”

“The FBI does not care about your status in life, your professional standing, your level of income, or your personal connections when you break the law," said Assistant Special Agent in Charge Wayne Jacobs of the FBI’s Newark Field Office. “If you try to scam the system, if you exploit your professional license just to pad your pockets, if you mortgage your morals just to inflate your bank account, you will only find yourself in deeper debt. We are committed to protecting the public; we are intent on rooting out fraud and corruption; we are duty-bound to track down and arrest anyone who is breaking our federal laws. Don’t be next.”

“Healthcare fraud is not a victimless crime—with unscrupulous providers preying on Medicare beneficiaries and taxpayers alike. Especially insidious is the fraud committed by healthcare professionals who are trusted to provide needed, quality services to patients,” said Special Agent in Charge Scott J. Lampert of HHS-OIG. “With our law enforcement partners, our agency will continue to thoroughly investigate medical providers and others involved in healthcare fraud.”

“The physicians who chose to violate their oaths to “Do no harm” are nothing more than drug dealers wearing a white lab coat,” said Special Agent in Charge Susan A. Gibson of the Drug Enforcement Administration’s New Jersey Field Division. “They have turned their backs on those most vulnerable. We will continue to vigorously pursue these doctors who violate the faith and trust of those who need help.”

****

Among those charged in the District of New Jersey are the following:

Elliot Loewenstern, 56, of Boca Raton, Florida, the vice president of marketing of purported call centers and telemedicine companies, pleaded guilty on Sept. 24, 2019, for his role in one of the largest health care fraud schemes ever investigated by the FBI and HHS-OIG and prosecuted by the Department of Justice, which resulted in charges in April 2019 against 24 defendants. Loewenstern pled guilty to one count of conspiracy to defraud the United States and pay and receive health care kickbacks, and one count of solicitation of health care kickbacks. Loewenstern was the Vice President of Marketing of PCS CC LLC and a marketer for Video Doctor USA (Video Doctor) and Telemed Health Group LLC (AffordADoc) (collectively, the Video Doctor Network). In connection with his plea agreement, Loewenstern admitted causing the submission of over $424 million in fraudulent claims that resulted from the solicitation of illegal kickbacks and bribes in exchange for the referral of brace orders to brace providers. In connection with his guilty plea, Loewenstern admitted that he and others agreed to solicit and receive illegal kickbacks and bribes from patient recruiters, brace suppliers and others in exchange for the arranging for doctors to order medically unnecessary orthotic braces for beneficiaries of Medicare and other insurance carriers. The beneficiaries were contacted through an international telemarketing network that lured hundreds of thousands of elderly and/or disabled patients into a criminal scheme that crossed borders, involving call centers in the Philippines and throughout Latin America, Loewenstern stated. Loewenstern admitted that many of these orders were written after only a short telephone call between the health care provider and the beneficiary, with whom the health care provider had no prior doctor-patient relationship. In addition, Loewenstern admitted that he was aware that the owners and other executives of the Video Doctor Network schemed to defraud investors and others by making false and fraudulent representations that the Video Doctor Network was a legitimate telemedicine enterprise that made revenue of “$10 million per year” and “20 percent profit” from payments by beneficiaries who enrolled in a membership program and paid for the telemedicine consultations. These statements were false because revenue was obtained by the Video Doctor Network through the receipt of illegal kickbacks and bribes, Loewenstern admitted. In connection with his plea agreement, Loewenstern agreed to pay $200 million in restitution to the United States, as well as forfeit assets and property traceable to proceeds of the conspiracy to defraud the United States. Loewenstern’s sentencing is set for Jan. 9, 2020, before U.S. District Judge Madeline Cox Arleo of the District of New Jersey, who accepted his plea. Loewenstern was charged along with Creaghan Harry, 51, of Highland Beach, Florida, and Lester Stockett, 52, of Medellin, Colombia, in an indictment charging one count of conspiracy to defraud the United States and pay and receive health care kickbacks and four counts of health care kickbacks. Stockett and Harry were separately charged with one count of conspiracy to commit money laundering. Stockett, the Chief Executive Officer, previously entered a plea of guilty to one count of conspiracy to defraud the United States and one count of money laundering. The case against Harry is pending. Trial has not been set. The case was investigated by FBI, HHS-OIG, and IRS-CI. The case is being prosecuted by Acting Assistant Chief Jacob Foster and Trial Attorney Darren Halverson of the Criminal Division’s Fraud Section.

Joseph DeCoroso, M.D., 62, of Toms River, New Jersey, pleaded guilty for his role in a $13 million conspiracy to commit health care fraud and separate charges of health care fraud for writing medically unnecessary orders for durable medical equipment (DME), in many instances without ever speaking to the patients, while working for two telemedicine companies. Sentencing is set for Jan. 8, 2020. The case was investigated by FBI Newark and HHS-OIG. The case is being prosecuted by Acting Assistant Chief Jacob Foster and Trial Attorney Darren Halverson.

Nelly Petrosyan, 56, of New York, New York, the owner and operator of orthotic brace suppliers in New York, New York, was indicted on one count of conspiracy to defraud the United States and to pay and receive health care kickbacks and three counts of payment of health care kickbacks. The charges result from a $5.6 million conspiracy in which Petrosyan offered and paid kickbacks and bribes to several purported telemedicine companies in exchange for completed doctors’ orders of medically unnecessary orthotic braces for Medicare beneficiaries. Petrosyan and her coconspirators concealed the fraud by entering into sham contracts and producing false invoices characterizing the kickbacks and bribes as payments for “marketing.” The investigation was conducted by FBI Newark and HHS-OIG. The case is being prosecuted by Trial Attorney Darren Halverson.

Alice Chu, M.D., 62, of Fort Lee, New Jersey, was indicted on one count of conspiracy to commit health care fraud and four counts of health care fraud. The charges stem from Chu’s alleged submission of false and fraudulent claims to Medicare and private insurance companies for services that were medically unnecessary, never provided, not provided as represented or not eligible for reimbursement. Chu was allegedly induced by a financial incentive to order expensive and medically unnecessary lab tests that were paid for by Medicare. The investigation was conducted by FBI Newark, HHS-OIG, DOD-DCIS and FDA-OIC. The case is being prosecuted by Trial Attorney Rebecca Yuan of the Fraud Section.

Aaron Williamsky 59, of Marlboro, New Jersey, and Nadia Levit, 40, of Englishtown, New Jersey, owners of approximately 25 durable medical equipment companies, pleaded guilty on Sept. 18 and Sept. 25, respectively, for their participation in a health care fraud scheme related to their payment of kickbacks in exchange for doctors' orders for medically unnecessary orthotic braces. Levit's conduct admittedly caused losses in excess of $120 million and Williamsky's conduct admittedly caused losses in excess of $170 million. Williamsky also pleaded guilty to a money laundering conspiracy related to his attempt to conceal at least $1.65 million of the proceeds of the fraud. The case was investigated by FBI, HHS-OIG, and IRS-CI. The case is being prosecuted by Assistant U.S. Attorneys Sean Sherman and Stephen Ferketic of the District of New Jersey.

Bernard Ogon, M.D., 46, of Burlington, New Jersey, pleaded guilty on Sept. 25 to one count of health care fraud conspiracy for his participation in a vast compounded medication telemedicine conspiracy. As part of the conspiracy, Ogon admittedly signed prescriptions for compounded medications (that is, medications with ingredients of a drug tailored to the needs of a particular patient) without having established a doctor-patient relationship, spoken to the patient or conducting any medical evaluation. Ogon often signed preprinted prescription forms—with patient information and medication already filled out—where all that was required was his signature. Then, instead of providing the prescription to the patient, Ogon would return the prescriptions to specific compounding pharmacies involved in the conspiracy. Ogon was paid $20 to $30 for each prescription he signed, and his participation in the conspiracy caused losses to health care benefit programs of over $24 million, including losses to government health care programs of over $7 million. The case was investigated by FBI Newark and HHS-OIG. The case is being prosecuted by Assistant U.S. Attorney Jason Gould of the District of New Jersey.

Joseph Santiamo, 64, of Staten Island, New York, a physician specializing in internal medicine and geriatrics was charged for allegedly conspiring to distribute and dispense controlled substances, including oxycodone, in exchange for sexual favors, and outside the usual course of professional practice and not for a legitimate medical purpose. The case is being prosecuted by Assistant U.S. Attorney Brian Urbano of the District of New Jersey.

Yana Shtindler, 44, of Glen Head, New York; Samuel "Sam" Khaimov, 47, of Glen Head, New York; Alex Fleyshmakher, 33, of Morganville, New Jersey; and Ruben Sevumyants 36, of Marlboro, New Jersey were indicted in connection with a scheme at Prime Aid Pharmacies (located in Union City, New Jersey and Bronx, New York) that included: (a) paying illegal bribes and kickbacks to doctors and doctors' employees in exchange for prescription referrals to Prime Aid; (b) billing health insurance providers for medications that were never actually provided to patients; and (c) opening new pharmacies and concealing the true ownership of those pharmacies to obtain lucrative contracts they otherwise would not have obtained. The scheme of billing for medications that were never dispensed to patients was so egregious that Prime Aid received reimbursement payments of over $65 million for prescription medications that it never even ordered from distributors or had in stock. In total, Prime Aid's multiple schemes defrauded Medicare, Medicaid, and private insurers out of at least $99 million. The case is being prosecuted by Assistant U.S. Attorney Joshua Haber of the District of New Jersey.

Eduard "Eddy" Shtindler, 36, the owner and operator of Empire Pharmacy in West New York, New Jersey, was charged by criminal complaint for paying bribes to a psychiatrist in Hudson County, New Jersey, to induce the doctor to send prescriptions to Empire. On occasion, Shtindler secreted cash bribes in pill bottles that were delivered to the doctor. In exchange for these bribes, the doctor steered patients to Empire pharmacy. In addition, starting in 2015, Empire – at Shtindler's direction – perpetrated a fraudulent scheme to induce doctors to send expensive specialty medication prescriptions to Empire. Specialty medications often required "prior authorization" before being approved for reimbursement by Medicare, Medicaid, and some private insurance providers. To receive prior authorization approval more quickly and successfully than any other pharmacies, Empire employees, including two pharmacists, repeatedly falsified prior authorization forms for medications for various conditions, including psoriasis and Hepatitis C. In total, Empire defrauded Medicare and Medicaid out of at least $2 million. The case is being prosecuted by Assistant U.S. Attorney Joshua Haber of the District of New Jersey.

Matthew S. Ellis, 53, of Gainesville, Florida; Edward B. Kostishion, 59, Lakeland, Florida; Kyle D. Mclean, 36, of Arlington Heights, Illinois; Kacey C. Plaisance, 38, of Altamonte Springs, Florida; Jeremy Richey, 39, of Mars, Pennsylvania, and Jeffrey Tamulski, 46, of Tampa, Florida were indicted in connection with a genetic testing health care fraud scheme. Kostishion, Plaisance, and Richey operated Ark Laboratory Network LLC (Ark), a company that purported to operate a network of laboratories that facilitated genetic testing. Ark partnered with Privy Health Inc., a

company that McLean operated, and another company to acquire DNA samples and Medicare information from hundreds of patients through various methods, including offering $75 gift cards to patients, all without the involvement of a treating health care professional. Ellis, a physician based in Gainesville, served as the ordering physician who authorized genetic testing for hundreds of patients across the country that he never saw, examined, or treated. These included patients from New Jersey and various other states where Ellis was not licensed to practice medicine. Through this process, Ellis, Kostishion, Plaisance, and McLean submitted and caused to be submitted fraudulent orders for genetic tests to numerous clinical laboratories. These orders falsely certified that Ellis was the patients' treating physician and, in many cases, contained false information indicating that a patient had a personal or family history of cancer, when, in fact, the patient had no cancer history whatsoever. In 2018 alone, Medicare paid clinical laboratories at least approximately $4.6 million for genetic tests that Ellis ordered in this manner. In addition, Kostishion, Plaisance, Richey and Tamulski entered into kickback agreements with certain clinical laboratories under which the laboratories would pay Ark a bribe in exchange for delivering DNA samples and orders for genetic tests. The bribe payments were based on the percentage of Medicare revenue that the laboratories received in connection with the tests. Among other things, Kostishion, Plaisance, Richey, and Tamulski concealed these kickback arrangements through issuing sham invoices to laboratories that purportedly reflected services provided at an hourly rate even though the parties had already agreed upon the bribe amount, which was based on the revenue the laboratories received. In 2018, the clinical laboratories paid Ark at least approximately $1.8 in bribes. The case is being prosecuted by Assistant U.S. Attorney Bernard Cooney of the District of New Jersey.

Among those charged in the Eastern District of Pennsylvania are the following:

Timothy F. Shawl, 60, of Garnet Valley, Pennsylvania, a medical doctor, was charged with five counts of unlawful distribution of controlled substances. He allegedly wrote prescriptions for controlled substances that were outside the usual course of professional practice and not for a legitimate medical purpose. Shawl allegedly wrote prescriptions for controlled substances for patients without seeing, treating or examining them. Shawl allegedly prescribed hundreds of prescriptions for oxycodone to approximately 16 patients amounting to over 29,000 oxycodone tablets. The FBI conducted the investigation. The case is being prosecuted by Trial Attorney Debra Jaroslawicz of the Fraud Section.

Neil K. Anand, M.D., 42, of Bensalem, Pennsylavia, and Asif Kundi, 31, Atif Mahmood Malik, 34, and Viktoriya Makarova, 33, all of Philadelphia, Pennsylvania, Anand, a medical doctor, Kundi and Malik, unlicensed foreign medical school graduates, and Makarova, a nurse practitioner, were indicted on one count of health care fraud and one count of conspiracy to distribute controlled substances. The charges stem from the defendants' alleged submission of false and fraudulent claims to Medicare, health plans provided by the U.S. Office of Personnel Management (OPM) and Independence Blue Cross (IBC). The claims allegedly were for "Goody Bags," bags of medically unnecessary prescription medications that were dispensed by non-pharmacy dispensing sites owned by Anand. In total, Medicare, OPM and IBC allegedly paid over $4 million for the Goody Bags. Patients were allegedly required to take the Goody Bags in order to receive prescriptions for controlled substances. Malik and Kundi allegedly wrote prescriptions for controlled substances using blank prescriptions that were pre-signed by Anand or Makarova. Anand and Makarova allegedly prescribed over 10,000 prescriptions for Schedule II controlled substances, of which over 7,000 were for oxycodone totaling over 634,000 oxycodone tablets. The investigation was conducted by the FBI, HHS-OIG, USPS-OIG and OPM. The case is being prosecuted by Trial Attorney Debra Jaroslawicz.

Twelve indictments were unsealed involving charges against 12 people for allegedly possessing oxycodone with intent to distribute. The indictments charge that, from September 2016 through June 2019, the 12 defendants all presented forged prescriptions for oxycodone to various pharmacies outside of Philadelphia, in order to obtain oxycodone to distribute to others. The defendants, all from Philadelphia, drove many miles to pharmacies in Mt. Laurel, New Jersey, Marcus Hook, Pennsylvania, Drexel Hill, Pennsylvania, and Kennett Square, Pennsylvania. The defendants are charged with at least two, and up to 32, counts of possession with intent to distribute oxycodone. The defendants are charged with having received anywhere from 6,300 milligrams to 135,000 milligrams of oxycodone. According to the indictments, the defendants would often travel together to the pharmacies to fill their forged prescriptions. Charged were: Lamar Dillard, 37; Jermaine Grant, 29; Katrina Tucker, 32; Maurice Bertrand, 31; Courtney Brockenborough, 34; Alan Alexander Harrison, 29; Abdullah Howard, 23; Jonathan Metellus, 32; Clinton Monte Bullock; Crystal Coleman, 31; Marques Russell, 35, and Joseph Michael Simmons, 31. One defendant, Metellus, is also charged with one count of health care fraud, for allegedly using his Medicaid card to purchase prescription drugs with a forged prescription. The case was jointly investigated by the DEA's Tactical Diversion Squad, HHS-OIG, the Pennsylvania Department of State's

Bureau of Enforcement and Investigations, the Chester County District Attorney's Office and the Easttown Township Police Department. The cases are being prosecuted by Assistant U.S. Attorneys David E. Troyer, Elizabeth Abrams, Joan Burnes and Mary Kay Costello of the Eastern District of Pennsylvania.

Search and seizure warrants are being executed today at approximately six different locations. The search and seizures are being executed by law-enforcement officers from six federal agencies, including HHS-OIG, the FBI, USPS-OIG, DOL-OIG, DOD and OPM.

Among those charged in the Eastern District of New York are the following:

Anna Steiner, M.D., also known as "Hanna Wasielewska," 63, of Valatie, New York, a licensed anesthesiologist, was charged in a superseding indictment for an alleged $17.4 million health care fraud scheme related to the payment of kickbacks in return for the ordering of DME, prescription drugs and diagnostic tests that were not medically necessary and not the result of an actual doctor-patient relationship. Steiner was originally indicted on July 9, 2019. The case was investigated by FBI and HHS-OIG. The case is being prosecuted by Fraud Section Trial Attorney Andrew Estes.

Dr. Denny Martin, 46, of New York, New York, a licensed Neurologist, was charged in a complaint for an alleged healthcare fraud scheme related to the billing of doctor home visits where none actually occurred. The case is being prosecuted by Assistant U. S. Attorney William P. Campos.

Andrew Barrett, 60, of New City, New York, and his former wife, pharmacy owner Phyllis Pincus, 58, of New City, New York, were charged by indictment with healthcare fraud and false claims in a scheme where they billed insurers for medications not actually dispensed to patients. In 2016, Barrett was sentenced to 43 months' incarceration upon his guilty plea to tax fraud and healthcare fraud in which he billed insurers for medications not actually dispensed to patients. He was excluded from participation in the Medicare and Medicaid programs for over 20 years. The case is being prosecuted by Assistant U.S. Attorney William P. Campos.

Kevin McMahon, 31, of Seaford, New York, a registered professional nurse, was charged in a misdemeanor information with possession of fentanyl, which he obtained through the course of his employment at Nassau University Medical Center. McMahon will plead guilty to the information pursuant to a plea agreement and has agreed to surrender his nursing license at the time of his plea. The case is being prosecuted by Assistant U.S. Attorney Erin E. Argo.

Among those charged in the Western District of New York are the following:

Jillian Marks, 37, of Orchard Park, New York, a licensed nurse practitioner, was charged with obtaining controlled substances through fraud, wrongful use of government seal, and identity theft. With access to the Neighborhood Health Center in the City of Buffalo's internal computer databases, the defendant allegedly abused her position and illegally accessed the Allscripts prescription prescribing portal. Marks allegedly prescribed approximately 2,000 dosage units of controlled substances such as Adderall and Oxycodone, in the names of health center patients, which she then had filled and picked up at local pharmacies. At one point, Marks allegedly forged a letter from the DEA in order to appear "good" to her employer and allegedly used the DEA seal illegally. The DEA conducted the investigation. The case is being prosecuted by Assistant U.S. Attorneys Michael J. Adler and Misha A. Coulson of the Western District of New York.

Karen Melton, 45, of Cuba, New York, was charged with obtaining controlled substances through fraud. Melton, a medical secretary working for a physician in Olean, New York, was not licensed to prescribe controlled substances. However, Melton allegedly used her access within the office to issue fraudulent prescriptions in her own name in both paper and electronic form. The prescriptions were allegedly issued without a legitimate medical purpose. Between September 2016 and May 2019, Melton allegedly issued 59 fraudulent prescriptions for controlled substances, including hydrocodone. The DEA conducted the investigation. The case is being prosecuted by Assistant U.S. Attorneys Michael J. Adler and Misha A. Coulson.

Among those charged in the District of Connecticut are the following:

Philippe R. Chain, M.D., has entered into a civil settlement agreement with the U.S. Attorney's Office for the District of Connecticut, in which he will pay $300,000 to resolve allegations that he violated the False Claims Acts. Chain, who currently practices medicine in Florida, previously practiced medicine in Connecticut and performed telehealth services

from Connecticut for a telemedicine company located in Las Vegas, Nevada. The telehealth services Chain provided involved prescribing compounded medications to TRICARE beneficiaries. TRICARE is the federal health care program for active duty military personnel, retirees, and their families. The government alleges that Chain caused pharmacies to submit false claims for compounded medications to TRICARE by issuing or approving prescriptions which were invalid, because Chain did not speak with or examine the patients in question and did not have an established physician-patient relationship with them, in exchange for compensation paid to Chain. This matter was investigated by the U.S. Department of Defense, Office of Inspector General, Defense Criminal Investigative Service. The case is being prosecuted by Assistant U.S. Attorney Richard M. Molot of the District of Connecticut.

Among those charged in the Western District of Pennsylvania are the following:

Emilio Ramon Navarro, M.D., 58, of Coal Center, Pennsylvania, was charged with unlawfully dispensing controlled substances and health care fraud. Counts 1 – 28 of the Indictment allege that from April 2018 until April 2019, Navarro unlawfully distributed Oxymorphone and Oxycodone, Schedule II substances, to a person in return for sexual favors, either physically or by electronic communications, outside the usual course of professional practice and not for a legitimate medical purpose. Navarro is also charged in Count 29 with health care fraud for causing fraudulent claims to be submitted to Medicaid for payments to cover the costs of the unlawfully prescribed controlled substances. This case was investigated by the Western Pennsylvania Opioid Fraud and Abuse Detection Unit which includes: FBI, HHS-OIG, DEA, IRS-CI, Pennsylvania Office of Attorney General - Medicaid Fraud Control Unit, Pennsylvania Office of Attorney General – Bureau of Narcotic Investigations, USPS, Veterans Affairs-OIG, FDA-CI, OPM-OIG, and the Pennsylvania Bureau of Licensing. Assistant U.S. Attorneys Robert S. Cessar and Mark V. Gurzo are prosecuting the case.

Among those charged in the District of Columbia are the following:

Hope Falowo, a personal care aide, was charged by information with one count of healthcare fraud for her role in a $400,000 fraud scheme where she would bill Medicaid in the District of Columbia for services she never provided. The case is being prosecuted by Counsel to the Chief of the Health Care Fruad Unit Amy Markopoulos.

Nkiru Uduji, a personal care aide, pleaded guilty to one count of health care fraud conspiracy charged in an August 2019 Information. The charges stem from Uduji's role in a $600,000 fraud scheme in which she billed for more than 24 hours in a day, for services that were not rendered, and for services that were procured by kickbacks. The case is being prosecuted by Counsel to the Chief of the Health Care Fruad Unit Amy Markopoulos.

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.

The Fraud Section leads the Medicare Fraud Strike Force. Since its inception in March 2007, the Medicare Fraud Strike Force, which maintains 15 strike forces operating in 24 districts, has charged nearly 4,000 defendants who have collectively billed the Medicare program for more than $14 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.

Topic(s):
Opioids
Prescription Drugs
Health Care Fraud

Component(s):
Criminal Division
Criminal - Criminal Fraud Section
USAO - Connecticut
USAO - District of Columbia
USAO - New Jersey
USAO - New York, Eastern
USAO - New York, Western
USAO - Pennsylvania, Eastern

USAO - Pennsylvania, Western

Press Release Number:
19-1035

Updated September 26, 2019