NATIONAL HEALTH CARE FRAUD TAKEDOWN 2017: SUMMARY

The 2017 National Health Care Fraud Takedown (2017 HCF Takedown) was led and coordinated by the Criminal Division, Fraud Section's Health Care Fraud (HCF) Unit in conjunction with the Medicare Fraud Strike Force, a partnership between the Criminal Division, nine U.S. Attorney's Offices, the FBI, and the Department of Health and Human Services – Office of the Inspector General (HHS-OIG). In addition, the 2017 HCF Takedown includes the participation of the greater U.S. Attorney's Office community, Drug Enforcement Administration (DEA), Defense Criminal Investigative Service (DCIS), and State Medicaid Fraud Control Units. The 2017 HCF Takedown is the single largest health care fraud law enforcement operation in history.

Largest Number of Defendants and Medical Professionals Charged

- **412** individuals charged.
    - This figure represents a 37% increase from the 2016 HCF Takedown.
- **115** medical professionals charged, including **56** doctors.
    - These figures represent an 89% increase from the 2016 HCF Takedown.

Largest Fraud Loss Ever Charged

- Approximately **$1.3 billion** in false and fraudulent billings to Medicare, Medicaid, TRICARE, and other federal and private insurance programs.
    - This figure represents a 44% increase from the 2016 HCF Takedown.

Largest Number of Opioid Defendants Charged in a Health Care Fraud Takedown

- **120** individuals, including **27** doctors, charged in cases involving the distribution of opioids.
    - 56% of these doctors were charged by the Fraud Section's HCF Unit.
    - Opioid-related charges were brought across **21** federal districts.

Federal and State Partnership to Combat Health Care Fraud and Opioid Epidemic

- **41** federal districts participated, the largest ever USAO participation.
- **30** State Medicaid Fraud Control Units participated, representing 30 states.
- HCF Unit attorneys charged 121 individuals with fraud loss of **$762 million**, accounting for approximately 38% of federal defendants charged and 59% of total loss.
- Since 2007, the Strike Force program has prosecuted over **3500** defendants in cases involving over **$12.5 billion** in losses to Medicare and other federal programs.

2017 HEALTH CARE FRAUD TAKEDOWN: KEY OPIOID CASES

The summaries below are according to allegations in court documents. An indictment, complaint or information is merely an allegation and all defendants are presumed innocent unless and until proven guilty beyond a reasonable doubt in a court of law.

Sober Home Case (*United States v. Eric Snyder*) (SDFL); Alleged Fraud Loss: $58 million
This case centers on an alleged scheme to defraud private insurance companies out of over $58 million for treatment purportedly provided to individuals suffering from drug addiction. Instead of providing legitimate drug addiction treatment, Eric Snyder and his co-conspirators, through a Palm Beach County, Florida addiction treatment center and purported sober home that Snyder controlled, are alleged to have billed for: intensive addiction treatment services when patients were not even at the facility, and drug tests where samples were split multiple times in order to bill for multiple tests on the same sample. In order to entice drug addicted individuals to agree to be patients at the treatment center, Snyder is alleged to have provided many of them with housing, and offered other enticements including free airline travel, gift cards, trips to casinos and even strip clubs. Snyder and his co-conspirators are also alleged to have provided opioid drugs to individuals as an enticement to serve as patients and to ensure that they would test positive for opioids so that they appeared eligible for the purported treatment. In order to cover up the charged fraud, it is alleged that patient records, including therapy notes and patient intake forms, were falsified and backdated.

Tri-County Network Case (*United States v. Mavshiyat Rashid, et al.)* (EDMI); Alleged Fraud Loss: $164 million
Six physicians and the owner of a home health agency were charged with participation in a $164 million scheme related to the Tri-County Network (which is alleged to involve five medical clinics, a laboratory, and a physical therapy company) and its business partners and associates. The indictment alleges that the Tri-County Network was a one-stop shop for Medicare fraud in the Detroit-area, which involved numerous physicians prescribing medically unnecessary controlled substances, some of which were sold on the street, and billing Medicare for facet joint injections, drug testing, and other procedures that were medically unnecessary and/or not provided. In addition to the charges, seizure warrants have been executed on approximately $12 million in alleged proceeds from the scheme.

Gulfton Clinic Case (*United States v. Gazelle Craig, et al.)* (SDTX); Opioids Allegedly Distributed: Approximately 2.5 million illegal dosages
The Gulfton Clinic is an allegedly unregistered pain clinic in Houston, Texas – owned by Shane Faithful – that is alleged to have sold medically unnecessary prescriptions for Hydrocodone and other controlled substances issued by Dr. Gazelle Craig in exchange for $300 in cash per visit. Both Dr. Craig and Faithful are charged with the illegal distribution of controlled substances. As part of the scheme, Faithful allegedly employed armed security guards to patrol the clinic on a daily basis to control the crowds of people which ranged from addicts to "crew leaders," who brought people to the clinic to obtain prescriptions. The Gulfton clinic allegedly utilized strict measures to evade law enforcement, including instructing patients to turn off cell phones and other electronic devices before entering the clinic. After visiting the clinic, the Indictment alleges that the patients would take the fraudulent prescriptions to pharmacies that would dispense the opioids and other drugs prescribed by Dr. Craig.