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U.S. Healthcare Fraud Takedown 2025:

A White Paper Synthesizing one of the Largest
Enforcement Actions in American History

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Executive Summary

In June 2025, the U.S. Department of Justice (DOJ), in coordination with the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), Drug Enforcement Administration (DEA), and 50 U.S. Attorneys' Offices, executed the largest healthcare fraud enforcement operation in American history. The takedown resulted in 324 defendants charged across 50 federal districts and 12 State Attorneys General Offices, uncovering more than $14.6 billion in fraudulent claims. This white paper outlines the scope of the investigation, mechanisms of fraud, enforcement outcomes, and policy recommendations with the goal of enhancing compliance, oversight, and fraud prevention.

Scope of the DOJ Investigation

The time frame of the investigated fraudulent schemes spanned from 2018 to 2025, with peak activity between 2021 and 2024, coinciding with the COVID-19 pandemic and emergency billing waivers. **The individuals involved in these schemes were: 96 licensed medical professionals, including physicians, nurse practitioners, and pharmacists.** These individuals were all charged, underscoring the infiltration of fraud into legitimate healthcare practices.

Defendants were charged in all 50 federal districts and within 12 State Attorneys' General Offices. The most notable cases include a Grayslake, Illinois-based individual indicted for submitting $17.3 million in false claims through fictitious therapy entities, transnational criminal networks operating out of Russia and Eastern Europe targeting Medicare through U.S.-based shell companies, and fraud rings in Florida, Texas, California, and New York involved in telemedicine, genetic testing, and opioid diversion schemes.

Key Fraud Schemes Identified

TELEMEDICINE & GENETIC TESTING FRAUD

Of the 96 licensed medical professionals

49

INDIVIDUALS

were charged across states including **Florida, California, and New Jersey** in relation to these schemes.

Schemes involved **misleading telemarketing targeting seniors,** and billing for unnecessary or nonexistent genetic tests.

One case involved

$ 46 million

in fraudulent Medicare claims using **stolen health data and falsified consent recordings.**

Key Fraud Schemes Identified (cont.)

DURABLE MEDICAL EQUIPMENT (DME)

➢ **29 defendants tied to transnational networks** based in Russia and Eastern Europe.

➢ **Fraudsters acquired dozens of U.S. medical supply** companies through straw owners.

➢ **Fraudsters submitted $10.6 billion in false claims** using more than 1 million stolen identities, billing Medicare for items like urinary catheters that were never delivered.

Critical Findings

1
Medicare Advantage Risk Score Manipulation
Providers in states such as Texas, Arizona, and Michigan inflated diagnoses to boost risk scores. The DOJ flagged anomalous billing patterns using AI and machine learning, revealing systemic abuse of Medicare Advantage coding practices.

2
COVID-19 Relief Fraud
Defendants in New York, Illinois, and Georgia exploited emergency waivers to submit claims for fake testing sites, PPE supplies, and telehealth services. Fraud was enabled by relaxed documentation requirements during the pandemic.

3
Opioid Diversion
74 individuals were charged, including 44 licensed professionals, in states like West Virginia, Ohio, and Kentucky. Schemes involved illegal distribution of more than 15 million opioid pills through pill mills, forged prescriptions, and kickbacks.

Critical Findings (cont.)

4

Enforcement Outcomes

The DOJ has performed asset seizures of $245 million confiscated at this time, including cash, cryptocurrency, luxury vehicles, and real estate across states such as Florida, California, and Illinois. CMS prevented more than $4 billion in fraudulent payments from being disbursed by blocking the payments process.

To date, 106 defendants have reached civil settlements totaling $34.3 million. With these settlements, many did not receive jail time. However, they have been blocked from Medicare entitlement.

Billing privileges of these providers were revoked or suspended for 205 providers nationwide, including high-volume offenders in Texas, Florida, and New York.

5

Technology & Data Analytics

➢ DOJ's Health Care Fraud Data Fusion Center: Centralized fraud detection hub using AI to integrate data from CMS, HHS-OIG, DEA, and the FBI.

➢ CMS's Fraud Prevention System (FPS): Machine learning flagged suspicious billing behavior across billions of claims.

➢ Operation Gold Rush AI Tools: Prevented $4.45 billion in Medicare payments by identifying anomalies in DME billing.

Policy Implications & Recommendations

Based on the findings, below are recommendations to safeguard your practice, system, patients, and providers. Implementing these controls can help to mitigate risk and prevent the opportunity for fraudulent activities and bad actors from infiltrating your organization.

- ✔ **Telehealth Oversight:** Enforce stricter credentialing and audit trails for remote services to prevent misuse.

- ✔ **Risk Score Audits:** Mandate independent reviews of Medicare Advantage Coding to detect upcoding.

- ✔ **Real-Time Analytics Expansion:** Scale AI tools across CMS and DOJ for proactive fraud detection.

- ✔ **Whistleblower Incentives:** Enhance protections and financial rewards under the False Claims Act.

- ✔ **Cross-Agency Collaboration:** Continue the "whole-of-government" approach to share data and coordinate enforcement.

Conclusion

The 2025 healthcare fraud takedown marks a historic milestone in U.S. enforcement. It reveals the scale of systemic abuse and the power of data-driven detection. As fraud tactics evolve, so must the safeguards. This operation sets a new benchmark for accountability, innovation, and the urgent need for education in compliance and CMS regulation. While investigations continue, enforcement alone is not enough. Legislative and regulatory reforms are urgently needed to restore integrity to Medicare and protect the public trust.

REFERENCES

1. *Crain's Chicago Business:* Grayslake Man Indicted in $17.3M Healthcare Fraud
2. *DOJ Official Press Release:* 324 Defendants Charged in $14.6B Fraud
3. *HHS-OIG:* National Health Care Fraud Takedown Summary
4. *National Law Review:* DOJ's Record-Breaking Health Care Fraud Takedown

Next Steps

Optimize Your Healthcare Revenue Cycle

Navigating revenue cycle management can be challenging. We offer specialized advisory services to streamline your processes, ensuring efficiency and accuracy at every step. From enhancing patient access and registration to verifying insurance eligibility, we cover all aspects of the revenue cycle. Our team assists with prior authorizations, insurance verifications, and credentialing for providers and facilities, ensuring compliance and smooth revenue flow. With our comprehensive approach, you can optimize your revenue cycle and focus on delivering exceptional, HIPAA compliant patient care.

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Patient Financial Services	Denials Management
Revenue Integrity	Provider Education
Policy/SOP Compilation	Payer Enrollment
Billing System Implementation	New Practice Stand-up
Medical Claims Billing	Auditing of Coding & Documentation

Next Steps (cont.)

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- Do you want revenue cycle management that focuses on efficiency and improved patient outcomes and education?

About the Author

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View bio

Jolee is a self-motivated healthcare professional with more than 20 years of extensive experience in medical billing, coding, posting, credentialing, training, and Six Sigma/Lean methodologies. Her career achievements include streamlining medical billing processes, implementing efficient procedures, and creating educational programs for clinicians and providers. She has successfully managed revenue cycle activities, ensuring compliance with federal and state regulations, and has a deep understanding of third-party payer regulations. Her leadership in revenue cycle management has consistently delivered high-quality service and operational excellence.

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