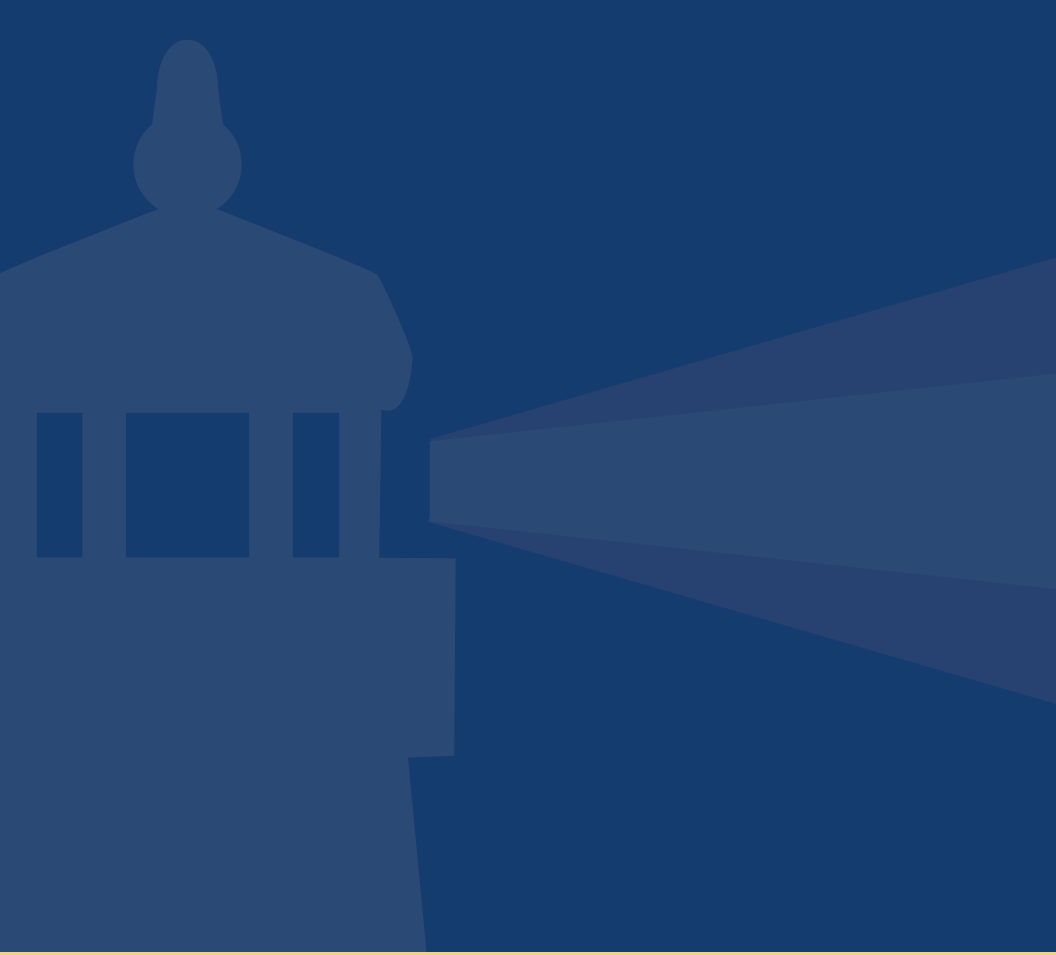

2025 NHCAA

Awards Program

November 20, 2025

NHCAA®

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NHCAA

John Morris Volunteer Service Award

National Health Care Anti-Fraud Association

Kurt S. Spear, CFE, CISSP

The NHCAA John Morris Volunteer Service Award recognizes an individual who has made an extraordinary contribution in support of the mission of the National Health Care Anti-Fraud Association.

NHCAA is delighted to name **Kurt S. Spear, CFE, CISSP, Vice President of Financial Investigations & Provider Review with Highmark Inc.** as the recipient of the **2025 NHCAA John Morris Volunteer Service Award**.

With more than 25 years of experience spanning global audit, investigative, compliance, and analytics functions, Kurt has built a reputation as a leader in the anti-fraud field. In his role with Highmark, Kurt leads one of the industry's most effective anti-fraud programs. Under his leadership, Highmark's Special Investigations teams collectively generate financial results exceeding $500 million annually.

Melissa Anderson, Executive Vice President and Chief Risk & Compliance Officer at Highmark Health, notes: "Kurt Spear exemplifies exceptional leadership, consistently fostering strong partnerships to combat fraud, waste, and abuse to protect our policyholders. His unwavering dedication and proactive support are invaluable in safeguarding resources and ensuring the integrity of the programs we implement."

Kurt's impact extends far beyond his organization. He has been an active volunteer and thought leader with NHCAA for many years, generously lending his expertise to strengthen the broader health care anti-fraud profession, sharing his knowledge through numerous speaking engagements and collaborative initiatives. He has presented at the Annual Training Conference and key webinars such as NHCAA's Top Schemes of 2023.

In 2024, NHCAA launched a work group devoted to examining the growing role of generative artificial intelligence (GenAI) and emphasizing its possibilities for fraud fighting. On behalf of the group, Kurt took it upon himself to write the initial draft of what later became NHCAA's Generative AI Issue Brief, published in June 2025. It is a pivotal work helping the industry understand and harness emerging AI technologies in the fight against health care fraud.

"His forward-thinking perspective and practical insights have been invaluable. NHCAA is grateful for Kurt's generosity of spirit and his willingness to collaborate across organizations for the greater good," says NHCAA CEO Louis Saccoccio.

Kurt has received numerous honors, including the DEA Award for Outstanding Contributions in Narcotic Investigations (2017), NHCAA's SIRIS Investigation of the Year (2019), and the NHCAA Excellence in Public Awareness Award—a distinction he has earned three times (2019, 2022, and 2024).

See more ▶

NHCAA

JOHN MORRIS VOLUNTEER SERVICE AWARD

National Health Care Anti-Fraud Association

Kurt S. Spear, CFE, CISSP

Prior to joining Highmark, Kurt served as a Senior Manager with Deloitte & Touche LLP, where he worked across diverse industries and regulatory environments, helping organizations strengthen compliance and control frameworks. A graduate of Marietta College, Kurt also holds professional certifications as a Certified Fraud Examiner (CFE) and Certified Information Systems Security Professional (CISSP) and is a proud graduate of both the DEA and FBI Citizen's Academies—further reflecting his deep commitment to collaboration with law enforcement and public sector partners.

Through his leadership, innovation, and volunteerism, Kurt embodies the mission and values of NHCAA. For his extraordinary contributions, NHCAA proudly recognizes Kurt S. Spear as the 2025 Volunteer of the Year.

HISTORY OF THE JOHN MORRIS VOLUNTEER SERVICE AWARD

This award was established in 2018 to honor the memory of one of NHCAA's most ardent and loyal supporters, John George Morris, Jr. A founding member of NHCAA in 1985, John served for many years on the NHCAA Board of Directors, including as Board Chair in 2003. Following his service to the Board, John continued to actively participate in NHCAA committees and activities and unselfishly volunteered his time and expertise to assist with countless NHCAA projects. Even in retirement he served, volunteering as an honorary NHCAA staff member at several Annual Training Conferences. John Morris was a true friend to the Association and his philosophy of service inspired NHCAA to inaugurate a volunteer service award in his honor.

NHCAA

Excellence in Public Awareness Award

National Health Care Anti-Fraud Association

SHUFFLE

A film by Benjamin Flaherty

The National Health Care Anti-Fraud Association proudly recognizes the powerful and deeply moving documentary film ***SHUFFLE*** with the **2025 Excellence in Public Awareness Award**.

SHUFFLE offers an unflinching look at the addiction treatment industry and how it often traps vulnerable people in a cycle where relapse is more profitable than recovery. Rarely has a film captured so clearly the complexity and insidious nature of a health care fraud scheme designed to maximize profits while callously disregarding those in desperate need.

Benjamin Flaherty serves as Writer, Director, Producer and Executive Producer of *SHUFFLE*. Drawing from his own transformative recovery, Flaherty discovered a world where addiction treatment can be little more than coordinated exploitation of addicts for profit—a revelation that inspired this film.

SHUFFLE follows three individuals whose lives depend not on entering treatment, but on surviving it, shedding light on the insurance-fueled cycle of addiction treatment fraud. The predatory nature of the scheme becomes clear, not only for addicts, but their families and loved ones as well. Personal stories provide the framework for a more public examination featuring an FBI informant, an insurance analyst, a seasoned reporter, and the former Executive Director of a treatment facility. *SHUFFLE* exposes a web of policy and private interests preying on a desperate population for profit.

In 2025, *SHUFFLE* has screened at numerous film festivals, earning several awards. A related impact campaign, Stop the Shuffle, includes university screenings and educational resources, with a wider theatrical release anticipated. Visit: www.stoptheshuffle.com

SHUFFLE

A FILM BY BENJAMIN FLAHERTY

2025 Winner

SXSW FILM & TV FESTIVAL
Documentary Feature Jury Award

LIGHTHOUSE INTERNATIONAL FILM FESTIVAL
Documentary Feature Jury Award

FLYOVER FILM FESTIVAL
Documentary Feature Jury Award

DIRECTOR'S STATEMENT

The participants in SHUFFLE trusted us in their most vulnerable moments with their most intimate truths. The film belongs to them. It is their story. I was the listener, the facilitator, the amplifier. My background as a person in recovery deeply informed my approach. I recognized the coded language of survival and the defensive humor in our subjects' voices. My goal was to craft a narrative that refused to flatten them into victims or heroes, and instead allowed their contradictions to remain intact. Directing SHUFFLE was an act of witness, accountability, and ultimately love.

NHCAA
SPECIALTY BENEFITS
INVESTIGATION OF THE YEAR
National Health Care Anti-Fraud Association

United States of America v. Rene Gaviola et al.

Floss Family Dental Care

The National Health Care Anti-Fraud Association is proud to recognize the investigation and prosecution teams in the case of **United States v. Rene Gaviola et al.** with this year's **Specialty Benefits Investigation of the Year Award**.

This case uncovered a far-reaching and deeply troubling Medicaid dental fraud scheme that put vulnerable children at risk and cost taxpayers millions. Led by a coordinated team of federal and state investigators, the case against Rene Fernandez Gaviola—operator, as well as effectively the owner of Floss Family Dental Care in Houston, Texas—exposed the deliberate exploitation of the Medicaid system through fraudulent billing, kickbacks, and unlicensed dental practices.

Between 2018 and 2021, using a Texas licensed dentist as a straw owner, Gaviola operated Floss Family Dental Care while falsely presenting himself as a licensed dentist. He paid kickbacks to patient recruiters and caregivers to bring Medicaid-insured children to the three clinic locations he oversaw, where most received only minimal treatment such as exams or cleanings. Despite this, Gaviola billed Medicaid for extensive procedures, including hundreds of cavity fillings that were never performed.

In a shocking breach of trust, Gaviola also employed unlicensed individuals—including his own son—to treat children and then billed Medicaid as if those services had been provided by a credentialed dentist. At times, the clinic even operated without a licensed dentist present. These actions not only defrauded the Medicaid program but also jeopardized the health and safety of the young patients who were placed in unqualified hands.

The fraud was detected through an innovative "impossible day" analysis conducted by dental benefits provider DentaQuest, a Sun Life Company. Investigators discovered that claims showed the same dentist allegedly performing multiple complex procedures at different locations simultaneously—an impossibility. Working together, DentaQuest, the Texas Medicaid Fraud Control Unit, the U.S. Department of Health and Human Services Office of Inspector General, the FBI, and the U.S. Attorney's Office for the Southern District of Texas uncovered falsified records, fabricated schedules, and systematic deception across the practice's operations.

The investigation revealed that Floss Family Dental Care billed Medicaid nearly $6.9 million for pediatric dental services, of which approximately $4.9 million was paid. Gaviola funneled much of this money through personal bank accounts, laundering Medicaid funds in multiple six-figure transactions.

In 2024, Gaviola pleaded guilty to 16 federal counts, including conspiracy to commit health care fraud, multiple counts of health care fraud, conspiracy to pay and receive kickbacks, and money laundering. Chief U.S. District Judge Randy Crane sentenced him to 10 years in federal prison, followed by three years of supervised release, and ordered restitution of $4.9 million to the Medicaid program and a personal money judgment of nearly $3 million. The court noted the gravity of Gaviola's actions—particularly his decision to involve his son in the scheme—and his continued concealment of assets overseas.

This case demonstrates the power of interagency collaboration and public-private partnership, combining analytical insight, investigative innovation, and a steadfast commitment to protecting patients and public funds. Thanks to these efforts, an egregious fraud was identified and the perpetrator brought to justice, safeguarding both the integrity of the Medicaid dental program and the well-being of countless children.

CONGRATULATIONS TO

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Investigations

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William Paul Dunn, *Special Agent*

UNITED STATES DEPARTMENT OF JUSTICE

Federal Bureau of Investigation

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DENTAQUEST, A SUNLIFE COMPANY

Special Investigations Unit

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NHCAA

SIRIS

INVESTIGATION OF THE YEAR

National Health Care Anti-Fraud Association

United States of America v. Barroga

The National Health Care Anti-Fraud Association proudly recognizes the investigation and prosecution teams in the case of **United States v. Barroga** with this year's **SIRIS® Investigation of the Year Award**.

This case uncovered a sophisticated and egregious health care fraud scheme at a Dallas pain management clinic, where twin brothers Drs. Desi and Deno Barroga exploited patients and defrauded insurers of tens of millions of dollars. The scheme took place between 2018 and 2022 and involved obligating patients to attend monthly office visits in exchange for receiving prescriptions for highly addictive controlled substances, including hydrocodone, oxycodone, and morphine.

The Barrogas regularly reported to insurance that they performed as many as 80 corticosteroid injections per patient per visit. While patients believed they were receiving legitimate injections, in many cases, the brothers would mimic giving injections without actually piercing the skin and then would create or clone fabricated medical records to support the fraudulent claims.

Attempts by the Barrogas to conceal the scheme heightened the complexity of the investigation. In order to evade detection, the brothers regularly billed their excessive injection services on two separate claims for the same patient/encounter, days to weeks apart, in an attempt to bypass the medically unlikely edits that the claim systems would have identified. They also instructed patients to provide false information to insurers. Their scheme involved deliberate concealment and misrepresentation, including splitting medical records into unique and separate procedure notes, falsifying patient histories, and altering business practices by directing patients to submit claims independently once investigations began.

A hallmark of this case was the effective sharing of investigative information facilitated through the NHCAA SIRIS® database. Blue Cross and Blue Shield of Texas was the first payor to enter a SIRIS record on the brothers, which prompted Cigna to contact BCBSTX to discuss their cases. In addition, the SIRIS database also displayed that UnitedHealthcare had viewed the record entered by BCBSTX. Cigna's investigation had revealed evidence of potential fraudulent claim submissions to UHC (as determined during a patient interview), prompting Cigna to immediately contact UHC to discuss these findings. Notably, Cigna used the SIRIS database to connect with the respective investigators within BCBSTX and UHC, and then later connected law enforcement with the impacted payors as well.

Without the SIRIS database, this collaboration would not have been possible, and the true scope of the brothers' fraud scheme may not have been uncovered. SIRIS played an invaluable role in the successful outcome of the case.

The cumulative effect of the scheme jeopardized patient safety, distorted medical records, and defrauded multiple insurers, including Blue Cross Blue Shield of Texas, Cigna, and UnitedHealthcare, resulting in at least $45 million in billed claims and approximately $9 million in payments. Investigative techniques—including patient interviews, exhaustive medical record review, clinical consultation, and collaboration with multiple federal and state agencies—were critical in bringing the case to resolution.

In May 2024, the Barrogas pleaded guilty to conspiracy to commit health care fraud. In September 2024, U.S. District Judge Brantley Starr sentenced each brother to 6½ years in federal prison and jointly ordered $9 million in restitution. The court also required the immediate surrender of their medical licenses and DEA registrations.

This case exemplifies the power of information sharing, interagency cooperation, data-driven investigation, and the SIRIS® database in revealing complex fraud schemes. The outcome not only held the perpetrators accountable but also protected patients, restored integrity to health benefit programs, and demonstrated the profound impact of collaboration between payors and law enforcement.

CONGRATULATIONS TO

UNITED STATES DEPARTMENT OF JUSTICE
Drug Enforcement Administration

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United States Attorney's Office
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Employee Benefits Security Administration

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HCSC, BLUE CROSS AND BLUE SHIELD OF TEXAS
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NHCAA

Investigation of the Year

Honorable Mention

National Health Care Anti-Fraud Association

United States of America v. Bethany A. Cataldi

The National Health Care Anti-Fraud Association is pleased to recognize the investigation and prosecution teams in the case of **United States of America v. Bethany A. Cataldi** with an **Investigation of the Year – Honorable Mention**.

Dr. Bethany Cataldi, an otolaryngologist and owner of the Center for Otolaryngology and Facial Plastic Surgery (COFPS) in Highland, Indiana, was the subject of a $22 million health care fraud investigation spanning four years. The case brought together a broad coalition of federal, state, and private partners, including the U.S. Department of Health and Human Services, Office of Inspector General, FBI, FDA, the U.S. Attorney's Office for the Northern District of Indiana, along with six major private health insurers.

The scheme centered on the billing of balloon sinuplasty procedures, a surgical outpatient treatment for chronic sinus infections. The case originated when HHS-OIG identified suspicious billing patterns and interviewed Medicare beneficiaries, many of whom confirmed they never received the billed procedures. From March 2015 through December 2023, Dr. Cataldi billed Medicare for 1,873 procedures, despite purchasing enough medical devices to perform only approximately 100.

The investigation also exposed COFPS's disorganized operations, including poorly maintained patient records and numerous medically unnecessary or substandard procedures, some of which left patients worse off.

Government investigators revealed that Dr. Cataldi extended her scheme beyond Medicare to private insurance companies. The FBI coordinated with insurers, analyzing thousands of claims and interviewing previously unidentified victims, and discovered $13.2 million in false billing. The total in submitted fraudulent claims for Medicare and private insurance together in this case was more than $50 million.

Federal agents conducted extensive financial investigations into Dr. Cataldi and her partner, tracing illicit funds to lavish personal purchases, including high-end vehicles, two homes valued at over $5 million, a collection of more than 115 guitars, and luxury Cartier and Mikimoto jewelry. Innovative investigative techniques allowed investigators to uncover the full scope of the fraud, linking these assets directly to proceeds from the fraudulent billing.

In June 2025, Dr. Cataldi pleaded guilty to health care fraud, acknowledging responsibility for bilking Medicare and private insurers out of more than $22 million. As part of her plea agreement, she will repay these funds and faces a possible maximum sentence of ten years in prison. Her sentencing is scheduled for the end of October 2025.

The Cataldi case highlights the merit of cross-agency collaboration and innovative investigative approaches. By combining federal resources, forensic accounting, subject matter expertise, and private-sector partnerships, law enforcement not only uncovered a complex fraud scheme but also ensured accountability and restitution for victims. The case demonstrates a relentless commitment to protecting vulnerable populations and safeguarding public and private health care funds, making it a standout example of effective fraud investigation.

CONGRATULATIONS TO

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Inspector General
Office of Investigations

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NHCAA

INVESTIGATION OF THE YEAR

HONORABLE MENTION

National Health Care Anti-Fraud Association

United States of America v. Hickman et al.

The National Health Care Anti-Fraud Association is pleased to recognize the investigation and prosecution teams in the case of **United States of America v. Hickman et al.** with an **Investigation of the Year – Honorable Mention**.

This compounding case addresses an astonishing $370 million health care fraud scheme that targeted the prescription drug benefits of New Jersey state employees and TRICARE beneficiaries.

Central Rexall Drugs, a Louisiana compounding pharmacy, and its executives, Christopher Kyle Johnston and Trent Brockmeier, orchestrated a sophisticated scheme to design and submit compounded medication claims aimed at maximizing insurance reimbursement while disregarding patient need. Medications often targeted for the scheme included pain, scar, and antifungal creams, as well as vitamin combinations.

The conspiracy involved physicians, pharmacists, and public employees—including police officers, firefighters, and teachers—who facilitated fraudulent prescriptions and received illicit proceeds. The case also included a high-profile murder for hire, highlighting the extreme risks investigators faced while pursuing justice.

From inception, this complex, multi-jurisdictional investigation required extraordinary interagency coordination. Overlapping jurisdictions, personnel implicated as subjects, and the sensitive nature of interviews involving public service employees challenged relationships across agencies. The investigative team skillfully mediated conflicts and managed territorial disputes while mitigating threats, witness tampering, and obstruction, thus maintaining operational cohesion of the case.

The investigative approach was methodical and document-intensive. Investigators issued over 300 Federal Grand Jury subpoenas and gathered more than 200 gigabytes of evidence, including 2,300 bank and patient records. Analysis revealed more than 20 shell companies used to launder criminal proceeds and exposed the fraud's fluidity, as perpetrators routinely reformulated compounds to circumvent insurer controls.

The team faced challenges including handwritten medical records, voluminous billing data that exceeded standard software limits, and the involvement of cash-based kickbacks. Innovative data analytics tools were developed, enabling efficient sorting, review, and cross-referencing of billing and prescription data. This approach was critical in linking fraudulent prescriptions to responsible parties, which would prove vital in securing convictions.

Interagency collaboration was central to the case's success. Agencies worked in tandem throughout the investigation conducting interviews, surveillance, and forensic analysis while coordinating across multiple jurisdictions, including trial preparation in New Jersey and Louisiana. This cross-programmatic effort ensured comprehensive coverage and enabled effective prosecution.

The investigation resulted in 77 individuals charged, four trials, more than $29 million in forfeiture, $370 million in restitution, and approximately $8 million in asset seizures, with additional sentencings still pending. As of March 2025, fifty people had been convicted or pled guilty in the overarching conspiracy. On March 10, 2025, Johnston and Brockmeier were found guilty of conspiracy to commit health care fraud, wire fraud, identity theft, and money laundering.

Beyond the financial recovery and convictions, this case helped restore public trust, strengthened interagency partnerships, and established innovative investigation methods for complex health care fraud.

CONGRATULATIONS TO

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Brandon Galloway, *Supervisory Special Agent*

ATLANTIC COUNTY PROSECUTOR'S OFFICE
James Scoppa, *Captain*

NHCAA

INVESTIGATION OF THE YEAR

HONORABLE MENTION

National Health Care Anti-Fraud Association

United States of America v. Mckinsey & Company, Inc. U.S. AND United States of America v. Martin Eric Elling

The National Health Care Anti-Fraud Association is pleased to recognize the dual investigations **United States of America v. McKinsey & Company, Inc.** and **United States of America v. Martin Eric Elling** and their associated teams with an **Honorable Mention for Investigation of the Year**.

The investigation into McKinsey & Company's consulting work for Purdue Pharma and the related criminal actions of former McKinsey senior partner Martin Elling represents a landmark effort in health care anti-fraud enforcement, marking the first time a management consulting firm and one of its executives were held criminally accountable for advising a client in ways that directly fueled the opioid epidemic.

Over 15 years, McKinsey advised Purdue on strategies to aggressively market OxyContin and "turbocharge" sales. Efforts included targeting high-value prescribers writing medically unnecessary prescriptions, developing brand loyalty programs, and guiding the rollout of reformulated OxyContin. This work generated over $93 million in consulting fees for McKinsey and resulted in false claims submitted to federal health care programs, endangering public health nationwide.

Parallel civil and criminal processes achieved a global resolution, culminating in a $650 million civil False Claims Act settlement, including forfeiture, civil penalties, and compliance reforms. A Corporate Integrity Agreement, commits McKinsey to implementing a robust compliance program that includes enhanced conflict-of-interest policies, document retention procedures, and a five-year prohibition on opioid-related consulting.

The investigation faced significant obstruction. Elling, who directed 30 McKinsey engagements with Purdue, knowingly deleted emails and documents from his company-issued laptop to impede the federal probe. Forensic analysis by the DOJ Cybercrime Lab, including recovery of deleted files, shadow copies, and file system data, was critical in documenting Elling's actions and supporting his prosecution.

These criminal and civil investigations demanded unprecedented interagency collaboration across several Federal and state agencies and jurisdictions. Coordination involved investigators, analysts, auditors, prosecutors, cybercrime experts, forensic accountants, and other anti-fraud professionals. The Virginia Medicaid Fraud Control Unit leveraged predictive analytics and e-discovery tools to review over ten million documents, isolate patterns of unnecessary prescribing, and trace financial benefits from fraudulent activity. Elling ultimately pleaded guilty, was sentenced to six months in federal prison, two years of supervised release, 1,000 hours of community service, and fined $40,000.

The investigative and legal teams conducted extensive witness and grand jury interviews, examined complex financial transactions, and coordinated with the FDA to resolve conflicts of interest arising from McKinsey's dual work for Purdue and regulators. This integration of forensic accounting, cyber forensics, and predictive analytics ensured both criminal accountability and systemic protections.

This investigation exemplifies exceptional interagency partnership and investigative innovation. By combining civil, criminal, and regulatory expertise, the team achieved historic accountability for corporate and individual misconduct and established safeguards to prevent future health care fraud in pharmaceutical consulting.

CONGRATULATIONS TO

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
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UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Office of Audit Services
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Richard Wheeler, *Investigator II*
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NHCAA

National Health Care Anti-Fraud Association

United States of America v. Jorge Zamora-Quezada

The National Health Care Anti-Fraud Association is honored to recognize the investigation and prosecution teams behind **United States of America v. Jorge Zamora-Quezada** with this year's coveted **Investigation of the Year Award**.

The investigation into Dr. Jorge Zamora-Quezada exposed one of the most nefarious and harmful health care fraud schemes in recent memory—an operation that preyed upon thousands of vulnerable patients through false diagnoses, unnecessary treatments, and fabricated medical records. From 2000 to 2018, Dr. Zamora-Quezada, a Texas rheumatologist, falsely diagnosed patients—including children, the elderly, and the disabled—with chronic and degenerative diseases such as rheumatoid arthritis. He regularly administered toxic and unnecessary medications to defraud Medicare, Medicaid, TRICARE, and private insurers of more than $118 million.

What began as patient complaints evolved into a major, multi-agency criminal investigation led by the Rio Grande Valley Health Care Fraud Task Force. This joint effort included HHS-OIG, the FBI, the Texas Health & Human Services Commission OIG, and the Texas MFCU, working in partnership with the U.S. Attorney's Office for the Southern District of Texas and the DOJ Criminal Division's Fraud Section. Insurer HCSC, Blue Cross and Blue Shield of Texas also provided valuable assistance in the case.

Together, these agencies combined investigative techniques, data analytics, and extensive victim outreach to uncover a decades-long pattern of deception that endangered patient lives and eroded public trust in health care. Investigators used advanced claims analysis and cross-agency data matching to identify patterns of excessive billing, same-day claims hundreds of miles apart, and falsified diagnostics.

As evidence mounted, investigators launched a large-scale victim identification effort. With more than 10,000 patients identified under Zamora-Quezada's care, the FBI and HHS-OIG established a dedicated victim hotline and email portal that received an overwhelming response—more than 4,000 individuals came forward, identifying themselves as victims, providing critical documentation and testimony that helped solidify the case.

The investigation's success depended on extraordinary collaboration across federal and state levels. Agents coordinated surveillance operations, executed search warrants, and seized concealed medical records—including thousands hidden in a dilapidated barn. Prosecutors and analysts worked in concert to align complex data with firsthand patient accounts, while uncovering Zamora-Quezada's efforts to obstruct justice through manufactured patient records and fabricated test results intended to mislead auditors and federal grand juries.

Evidence revealed that Zamora-Quezada used the illicit proceeds he collected to fund a lavish lifestyle, purchasing luxury vehicles, a private jet, and real estate across the United States and Mexico.

Court testimony from victims and medical experts detailed the physical and emotional toll of his conduct, including strokes, jawbone necrosis, and lasting trauma among patients who were misled to believe they had incurable diseases. Following a 25-day jury trial, Dr. Zamora-Quezada was convicted of conspiracy to commit health care fraud, health care fraud, and conspiracy to obstruct justice. In May 2025, he was sentenced to 10 years in federal prison and ordered to pay $28 million in restitution to Medicare, Medicaid, TRICARE, and Blue Cross and Blue Shield of Texas. He was also ordered to forfeit $28.2 million in assets, including 13 real estate properties, a private jet, and a Maserati.

This case exemplifies the strength of partnership and the profound impact of collaboration in combating health care fraud. The collective expertise of the investigative and prosecutorial team exposed the staggering scale of Zamora-Quezada's deceit and brought an end to years of unnecessary suffering. Their relentless pursuit of justice reflects the highest ideals and mission of the National Health Care Anti-Fraud Association.

CONGRATULATIONS TO

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Inspector General
Office of Investigations
Michael Garcia, *Special Agent*

UNITED STATES DEPARTMENT OF JUSTICE
Criminal Division, Fraud Section
Jacob Foster, *Principal Assistant Chief*
Emily Gurskis, *Assistant Chief*
Kevin Lowell, *Assistant Chief*
Rebecca Yuan, *Acting Principal Assistant Deputy Chief*

UNITED STATES DEPARTMENT OF JUSTICE
Federal Bureau of Investigation
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UNITED STATES DEPARTMENT OF JUSTICE
United States Attorney's Office
Southern District of Texas
Laura M. Garcia, *Assistant United States Attorney*
Andrew R. Swartz, *Assistant United States Attorney*

TEXAS HEALTH AND HUMAN SERVICES COMMISSION
Office of Inspector General
Miguel J. Ramirez, *Lieutenant*

TEXAS OFFICE OF THE ATTORNEY GENERAL
Medicaid Fraud Control Unit
Daniel Garza, *Task Force Officer*

HCSC, BLUE CROSS AND BLUE SHIELD OF TEXAS
Gerald L. Collins, *Senior Associate General Counsel*
Patty Escoe, *Vice President, Texas Plan Performance*
Lisa Mothershed, *Senior Manager*

Other Notable Nominations

1ST CLASS MENTAL HEALTH SERVICES CORP AND ETERNITY MENTAL HEALTH CORP

Between 2018 and 2022, investigators uncovered a large-scale Medicaid fraud scheme perpetrated by two Miami-Dade clinics, 1st Class Mental Health Services Corp. and Eternity Mental Health Corp. Collectively, they which submitted more than $16 million in false claims for psychosocial rehabilitative services. Clinic operators recruited Medicaid beneficiaries—many of them elderly or otherwise vulnerable—and paid kickbacks to patients and recruiters for participation in sham therapy sessions that never occurred. The defendants laundered the illicit proceeds through shell companies and spent the funds on luxury purchases, vacations, and personal expenses.

The four-year investigation, culminating in convictions between 2023 and 2025, used undercover operations, surveillance, and financial tracing to dismantle the fraud network. The case resulted in multiple prison sentences, including a 14-year term for the lead defendant, along with more than $15 million in restitution and forfeiture, serving as a strong deterrent against future large-scale Medicaid fraud schemes. This case was worked jointly as part of the Miami Healthcare Fraud Strike Force, and represented a collaborative effort between FBI, HHS-OIG, Florida MFCU, and the USAO in Southern District of Florida.

AMTRAK MULTI-YEAR NEW YORK HEALTHCARE FRAUD

An extensive investigation uncovered a large-scale conspiracy in which Amtrak employees and New York–area health care providers submitted false and medically unnecessary claims in exchange for cash kickbacks from providers. The scheme, which resulted in more than $11 million in fraudulent claims, operated from 2019 through 2022 and culminated in multiple arrests, guilty pleas, prison sentences, and substantial restitution orders.

Through undercover operations, data analysis, and coordinated prosecutions, investigators dismantled a widespread pattern of collusion between employees and providers that had become normalized within the benefits system. In total, four health care providers, a medical biller, a co-conspirator, and numerous Amtrak employees were criminally charged, with several convicted or sentenced. Administrative actions also followed, leading to the termination or resignation of 79 employees. Judicial outcomes included $10.42 million in court-ordered restitution, $2.62 million in additional settlements, and $676,000 in forfeiture by a provider. Amtrak OIG, the Amtrak Police Dept, and the DEA investigated the case, assisted by insurer Aetna. The USAO District of New Jersey prosecuted.

BROAD STREET FAMILY PHARMACY

A multi-year investigation uncovered a $20 million Medicare and Medicaid fraud scheme centered on Broad Street Family Pharmacy in South Philadelphia. Between 2016 and 2021, pharmacy operators billed government health programs for expensive medications—primarily the antipsychotic Latuda and several high-reimbursement HIV drugs—that were never dispensed. The pharmacy paid kickbacks to consumers who sold their prescriptions back for cash or other drugs and used a licensed pharmacist to conceal the owner's suspended credentials. Data analysis revealed that the pharmacy's billing for Latuda alone exceeded $7.5 million, more than ten times that of any other pharmacy in the country.

Through detailed data review, financial tracing, and undercover techniques, investigators exposed a sophisticated conspiracy that exploited vulnerable patients and diverted public health funds for personal gain. The investigation led to nine criminal charges, multiple guilty pleas, and more than $12 million in restitution. Key defendants received prison sentences, including up to five years for the operators. The joint investigation included the HHS-OIG and insurer AmeriHealth Caritas, and was prosecuted by the Pennsylvania Attorney General's Office.

GEORGIA ENT AND LABORATORY KICKBACK SCHEME

A long-running health care fraud and kickback scheme was uncovered involving Dr. Jeffrey Gallups and former Georgia Insurance Commissioner John Oxendine. The scheme centered on medically unnecessary sinus procedures, toxicology screenings, and genetic tests performed in exchange for illegal kickbacks from a laboratory company. Gallups and Oxendine directed staff to facilitate the fraudulent activity, resulting in millions of dollars in false claims submitted to insurers.

The investigation began after patient complaints revealed billing for procedures that were either not performed or lacked medical necessity. Through detailed data analysis, medical record reviews, and interviews, investigators identified patterns of systemic abuse and financial misconduct. The case led to multiple convictions and significant restitution, with Gallups sentenced to three years in prison and Oxendine to three and a half years, along with over $760,000 in restitution. The case underscores the power of coordinated investigative efforts in uncovering complex, provider-driven health care fraud schemes. The case was investigated by FBI, HHS-OIG, and DCIS, and prosecuted by USAO, Northern District of Georgia.

MAGELLAN TRIBAL OUTREACH PROGRAM

Magellan of Idaho, through its Special Investigations Unit (SIU), launched an innovative public awareness campaign to protect Tribal members from a growing sober home recruitment and Medicaid fraud scheme targeting Native American communities across the western United States. Developed in collaboration with Magellan's Tribal Liaison and Communications teams, the initiative focused on raising awareness among Idaho's six federally recognized tribes about fraudulent actors posing as treatment providers aiming to exploit vulnerable individuals under the guise of offering behavioral health or substance use services.

The SIU produced and distributed educational materials, hosted virtual presentations for the Northwest Portland Area Indian Health Board and the Idaho Tribal Technical Advisory Board, and published fraud prevention articles in Magellan Community Connection and Quarterly Peak newsletters. Social media campaigns, provider toolkits, and informational packets shared with Tribal health centers amplified the campaign's reach. By combining clear communication, cultural sensitivity, and strong collaboration with Tribal leadership, Magellan's outreach built trust, strengthened prevention networks, and helped protect Medicaid integrity and the well-being of Indigenous communities across Idaho and neighboring states.

See more ▶

Other Notable Nominations

OPERATION SUGAR AID

A two-year, multi-agency investigation, Operation Sugar Aid uncovered a large-scale prescription drug diversion and health care fraud network operating across Puerto Rico and the U.S. mainland. The investigation exposed an illicit enterprise responsible for diverting more than $13 million in prescription medications—including treatments for diabetes, thyroid disorders, and HIV—through patient buyback schemes, international sourcing, and hospital theft. Authorities identified twenty-seven defendants, including pharmacy owners, employees, and unlicensed distributors, who engaged in the wholesale distribution and sale of misbranded and diverted drugs originating from Colombia, Spain, and the Dominican Republic.

The operation was led by federal and state law enforcement, with key support from health insurers and pharmacy benefit managers and involved more than 6,000 investigative hours, extensive undercover work, and international coordination. By late 2024, most defendants had pleaded guilty, with several sentenced and others awaiting adjudication in 2025. The case produced over $2 million in civil recoveries and resulted in the largest seizure of misbranded and diverted prescription drugs in Puerto Rico, highlighting the critical role of vigilance and public-private collaboration in protecting patient safety and health care integrity. The case was investigated by HHS-OIG and the FDA Office of Criminal Investigations, with assistance from the U.S. Marshal Service and the Puerto Rico Police Bureau. The HHS-OIG Special Assistant U.S. Attorney prosecuted.

SMP ANNUAL MEDICARE FRAUD PREVENTION WEEK

The Senior Medicare Patrol (SMP) Resource Center, in partnership with the Administration for Community Living (ACL), leads Medicare Fraud Prevention Week (MFPW)—a coordinated, week-long campaign that empowers beneficiaries, caregivers, and professionals to prevent, detect, and report Medicare fraud, errors, and abuse. Held annually the week of June 5 ("6/5" symbolizing Medicare eligibility at age 65), the initiative engages all 54 SMP programs through nationwide education, outreach, and collaboration across the aging network.

In 2025, MFPW marked a milestone with the launch of the SMP Medicare Tracker app, a free public tool enabling users to monitor services, receive scam alerts, and report suspected fraud. The app also features the interactive "Fraud Busters" game to help users identify common fraud schemes. Nearly 95% of SMP projects hosted educational events, and hundreds of users downloaded the new app within weeks of launch. Amplified by national partners through media and community engagement, this initiative highlights SMP's leadership in advancing awareness, promoting vigilance, and protecting the integrity of Medicare nationwide.

TENNESSEE ACTUAL SAVINGS STRATEGIC INITIATIVE

The Tennessee Office of Inspector General (TN OIG), in collaboration with TennCare and the Department of Finance and Administration, launched the Actual Savings Strategic Initiative to transform how Medicaid fraud prevention results are measured and communicated. Under the state's Customer Focused Government Plan, the initiative shifts from estimating "potential savings" to calculating verifiable, data-driven outcomes that reflect actual dollars saved through OIG investigations and recommendations to end fraudulent or ineligible coverage.

Through quarterly cross-agency meetings, standardized tracking, and shared policy alignment, the TN OIG and TennCare created a unified system for verifying each dollar saved. In its first full fiscal year, the initiative reported $1.8 million in audited savings, marking a significant step toward greater transparency and accountability in Medicaid oversight. By replacing estimates with evidence, Tennessee established a model that enhances public trust, demonstrates measurable impact, and provides a replicable framework for other states to quantify and report the true results of their Medicaid fraud prevention efforts.

UNITED STATES OF AMERICA V. ANAND ET AL.

A multi-agency investigation uncovered a large-scale health care fraud and illegal opioid distribution scheme orchestrated by Dr. Neil Anand, a Pennsylvania-based pain management physician. From 2016 through 2020, Anand operated AOB Med Spa and Advanced OBGYN Institute as fronts for fraudulent billing, illegal drug dispensing, and kickback activity. He routinely prescribed high-dose opioids without medical justification and required patients to pay cash for unnecessary procedures. Anand also distributed pre-packaged "Goody Bags" containing opioids, benzodiazepines, and other controlled substances—billed to insurers as compounded medications that were never legitimately dispensed.

The investigation—led by federal and state law enforcement, with support from affected insurers—revealed falsified medical records, fraudulent billing, and money laundering across multiple entities. Investigators used data analytics, patient interviews, and financial tracing to expose the scheme and link fraudulent prescriptions to illegal drug distribution. In September 2025, Anand was sentenced to 14 years in federal prison and ordered to pay more than $2 million in restitution and forfeiture. The case was investigated by HHS-OIG, USPS OIG, and OPM OIG, prosecuted by the DOJ Criminal Division's Fraud Section.

UNITED STATES OF AMERICA V. DANIEL ALBERTO CARPMAN

This multi-year investigation uncovered a major prescription opioid diversion scheme involving Dr. Daniel Alberto Carpman, a Miami physician responsible for one of South Florida's largest illegal Oxycodone operations. Carpman conspired with drug traffickers to prescribe more than two million 30-mg Oxycodone tablets, typically reserved for end-of-life care, which were diverted to the illicit market with an estimated street value of $60 million.

Investigators found that Carpman's clinic was effectively controlled by drug dealers who managed patients and operations while the doctor issued high-dose prescriptions without proper examinations. He routinely socialized with co-conspirators and displayed a blatant disregard for medical ethics and patient safety. Using prescription data analysis, financial audits, and witness testimony, authorities traced the full extent of the fraud. Carpman was convicted and sentenced to 20 years in federal prison, marking a decisive victory in the fight against prescription drug diversion and opioid abuse. The case was investigated by HHS-OIG, FBI, and DEA, and prosecuted by the USAO, Southern District of Florida.

See more ▶

Other Notable Nominations

UNITED STATES OF AMERICA V. DEHSHID NOURIAN ET AL.

An investigation that uncovered one of the largest workers' compensation and compounding pharmacy fraud schemes ever prosecuted in Texas, involving Dehshid "David" Nourian, Christopher Rydberg, and their associates. The case began after unusually high reimbursement payments—totaling $90.9 million—from the Department of Labor's Office of Workers' Compensation Programs (DOL-OWCP) to three Fort Worth pharmacies operated by the defendants. Most prescriptions came from just three physicians who were paid kickbacks disguised as "loans." The pharmacies manipulated compounded medication formulas to maximize profits, disregarded medical necessity, and laundered proceeds through shell corporations and personal accounts.

Extensive data analysis and financial tracing exposed the scheme, resulting in convictions for Nourian, Rydberg, and Dr. Kevin Taba. Nourian and Rydberg received prison sentences of 210 and 180 months, respectively, and were ordered to pay more than $115 million in restitution. The court later ordered the forfeiture of $405 million in assets tied to Nourian's fraud and money laundering activities, marking one of the largest recoveries ever achieved by the health care fraud unit. The USPS OIG, DOL-OIG, VA-OIG, and IRS-CI investigated the case, and the DOJ Criminal Division's Fraud Section prosecuted.

UNITED STATES OF AMERICA V. MICHAEL KESTNER

An investigation revealed a widespread health care fraud scheme orchestrated by Michael Kestner, a non-practicing attorney and owner of Pain MD, which operated multiple clinics across Tennessee, Virginia, and North Carolina. Kestner directed medical staff to administer medically unnecessary injections, including Tendon Origin and Trigger Point Injections, to patients—many of whom sought legitimate pain treatment. He coerced compliance by threatening to withhold prescriptions and imposed productivity quotas that rewarded excessive procedures, prioritizing profit over patient safety. Between 2010 and 2018, Kestner and his clinics submitted approximately $35 million in fraudulent claims to government health programs.

Evidence showed Pain MD became the nation's highest biller for certain procedures, with providers trained to perform anatomically incorrect and ineffective injections. Kestner was convicted of conspiracy and multiple counts of health care fraud, and in 2025 was sentenced to 18 months in prison, ordered to pay $2.4 million in restitution, and forfeit $217,000. HHS-OIG, DCIS, VA-OIG, and TBI investigated the case, and the DOJ Criminal Division's Fraud Section prosecuted.

AWARDEE CONFERENCE SESSIONS

UNITED STATES OF AMERICA V. BARROGA

The recipients of NHCAA's 2025 SIRIS® Investigation of the Year Award will discuss the investigative strategies, multi-organization cooperation, and case-building excellence that led to the successful resolution of the investigation and the coveted NHCAA honor.

Thursday, November 20, 2025
2:45 PM – 3:45 PM
Volunteer Ballroom D
Gaylord Opryland Resort & Convention Center

UNITED STATES OF AMERICA V. RENE GAVIOLA ET AL.
Floss Family Dental Care

The recipients of NHCAA's 2025 Specialty Benefits Investigation of the Year Award will discuss the investigative strategies, multi-organization cooperation, and case-building excellence that led to the successful resolution of the investigation and the coveted NHCAA honor.

Thursday, November 20, 2025
4:00 PM – 5:00 PM
Volunteer Ballroom C
Gaylord Opryland Resort & Convention Center

UNITED STATES OF AMERICA V. JORGE ZAMORA-QUEZADA

The recipients of NHCAA's 2025 Investigation of the Year Award will discuss the investigative strategies, multi-organization cooperation, and case-building excellence that led to the successful resolution of the case and the coveted NHCAA honor.

Friday, November 21, 2025
9:00 AM – 11:00 AM
Ryman Ballroom B
Gaylord Opryland Resort & Convention Center

Our Mission *is to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution, and prevention of health care fraud and abuse.*

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