

2026 NHCAA

# Awards Program

*November 5, 2026*

NHCAA®

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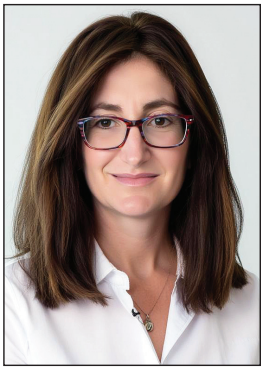
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NHCAA

John Morris Volunteer Service Award

National Health Care Anti-Fraud Association

# Karen Weintraub
# MA, AHFI, CPC-P, CPMA, CDC



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 **Karen Weintraub, MA, AHFI, CPC-P, CPMA, CDC**, as the recipient of the 2026 award, honoring her many years of generously sharing her time and expertise to advance the health care anti-fraud field.

For nearly two decades, Karen has contributed to the professional growth of NHCAA members as a volunteer instructor, mentor, and collaborator in the Association's educational programs. Her dedication reaches across disciplines, helping professionals grasp the connections among investigations, medical coding, claims review, data analysis, and fraud detection. Whether introducing newcomers to the field or exchanging insights with experienced colleagues, she brings a practical perspective and a sincere commitment to helping others succeed.

NHCAA CEO Louis Saccoccio offers, "Karen's relentless commitment to advancing the health care anti-fraud profession is matched only by the extraordinary heart she brings to helping others succeed. On behalf of NHCAA, I offer our deepest appreciation and respect for all she has given—and continues to give—to this community."

Karen began her health care anti-fraud career at Health Net in 2004, eventually becoming Supervisor of Investigations and managing cases across the Northeast for commercial, Medicaid, and Medicare business. She later managed Special Investigations Unit services at ViPS, a General Dynamics company, before joining Healthcare Fraud Shield in 2012, where she now serves as Executive Vice President.

A respected subject matter expert, Karen contributes to the design and development of fraud detection software, drawing on her knowledge of system workflows, business rules, data mining, fraud outlier algorithms, and SIU operations. This work keeps her closely engaged with evolving technologies and the changing needs of the industry. She brings that knowledge to her volunteer teaching, helping colleagues connect new capabilities with the practical demands of identifying and addressing health care fraud.

Karen's relationship with NHCAA began as an attendee of the Association's training programs in 2006. Then, a year later she became a presenter at the 2007 Annual Training Conference. Since then, she has spoken at dozens of NHCAA programs, covering fraud schemes, investigative strategy, coding, and analytics. She has a gift for breaking complicated subjects into understandable lessons, making technical material engaging and showing participants how to apply it in their respective roles.

Her longstanding involvement with NHCAA's Boot Camp program demonstrates the depth of her commitment. A seasoned authority, Karen devotes substantial volunteer hours to planning program sessions, reviewing and refining materials, and preparing new investigators for the

challenges ahead. Her contributions also extend to fellow faculty members: she encourages strong content and clear instruction, readily offering her own time to help others improve their presentations. Much of this effort takes place behind the scenes, but its value is felt throughout the program.

Together with industry colleague Matt Berls, Karen also created NHCAA's highly rated, multi-day Excel training program, offered from 2015 through 2020. They are now helping NHCAA create an on-demand Excel Training Hub intended for new investigators, representing the next iteration of how best to incorporate Excel into the investigative workflow. By helping participants strengthen their ability to examine claims data and recognize potential fraud, the course and forthcoming training hub address a practical need shared by professionals across the anti-fraud community. This work reflects Karen's willingness to turn her expertise into meaningful educational opportunities that benefit others.

Her generosity continues well beyond a scheduled training session. Karen regularly stays after presentations to answer questions and welcomes emails and follow-up inquiries, offering guidance as colleagues—old and new—work through challenges in practice. Those who learn from her remember both the substance of her instruction and the warmth and encouragement she brings to it, often accompanied by appearances from her beloved pets in her presentation materials. Although she generally prefers to stay out of the spotlight, Karen's calling to teach has made her a familiar, valued, and trusted presence in NHCAA's educational community.

The John Morris Volunteer Service Award honors the willingness to give one's time and wisdom freely for the benefit of others. Karen has exemplified that spirit through years of thoughtful preparation, approachable instruction, and sustained support for her peers. For her exceptional volunteer service and her enduring contributions toward the betterment of the health care anti-fraud profession, NHCAA proudly recognizes Karen Weintraub as its 2026 recipient of the John Morris Volunteer Service Award.

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### 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.*

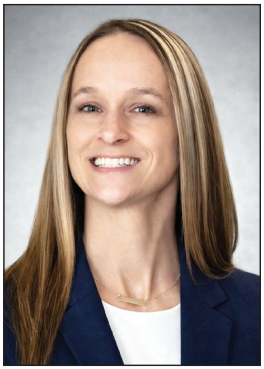
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Excellence in Public Awareness Award

National Health Care Anti-Fraud Association

# Comprehensive Health Care Fraud Awareness Strategy

## *Blue Cross Blue Shield of Michigan, Corporate & Financial Investigations* AND *Kelly Holbrook, PMP, SSGBC*



Blue Cross Blue Shield of Michigan

The National Health Care Anti-Fraud Association's Excellence in Public Awareness Award recognizes outstanding efforts to help people understand health care fraud and protect themselves from it. This year, NHCAA proudly names **Blue Cross Blue Shield of Michigan's Corporate & Financial Investigations** department and **Kelly Holbrook**, senior project consultant within that department, as joint recipients of the 2026 award. Together, they have built a comprehensive, multimedia approach that makes fraud education an ongoing part of the insurer's engagement with members, providers, employees, and the community.

The honor recognizes both Holbrook's leadership and BCBS of Michigan's decision to make fraud awareness a priority backed by lasting organizational resources. Holbrook led the transformation of periodic outreach into a coordinated, year-round strategy, while the company provided the communications infrastructure, enterprise participation, and executive support needed to bring that strategy to scale. The result shows how individual initiative and institutional commitment can work together to strengthen public understanding of health care fraud.

Colleagues point to the qualities that made that partnership possible. Daniel Crowell, senior director of BCBS of Michigan Corporate & Financial Investigations, says, "Kelly is the type of employee every organization hopes to have more of and one whom others can look to as a model. She is a collaborative team player, a dedicated advocate for the SIU, and consistently demonstrates a strong understanding of the broader business objectives. Her high level of emotional intelligence enables her to build strong relationships, navigate challenges effectively, and positively influence those around her."

The growth has been substantial. In 2025, annual fraud awareness outreach grew from roughly one million interactions to nearly 9.7 million, creating almost ten times as many opportunities to deliver prevention messages. That total included more than 9.2 million member interactions, 346,000 provider interactions, and 67,000 employee interactions, reflecting a deliberate effort to reach multiple audiences in varied settings.

Central to the strategy is a practical insight: prevention messages can reach people through the trusted channels they already use. BCBS of Michigan and Holbrook built guidance into member phone system messaging and Explanation of Benefits reminders, placing it within

routine interactions with the health plan. Articles in *MI Blue Daily*, LinkedIn posts, website resources, webinars, and podcasts carry that guidance across written, digital, video, and audio formats, while facility campaigns and an executive-sponsored fraud awareness video underscore the organization's commitment to prevention.

Whatever the channel, the goal is the same: translating complex fraud schemes into clear information people can act on. Members learn to recognize suspicious activity and better understand their benefits. Providers stay informed about emerging risks through resources such as *BCBSM Provider News* and provider alerts. Because this content is woven into established communications, fraud awareness stays visible throughout the year, with repeated opportunities to encourage vigilance and reporting.

Holbrook also gave particular attention to seniors, who are frequent targets of fraud. Dedicated initiatives and podcast discussions offer practical advice on recognizing scams, safeguarding personal information, and avoiding victimization. Backed by the company's broader outreach capabilities, this focus keeps the program relevant to the people it aims to protect and shows the value of tailoring education to specific risks.

Inside the company, fraud awareness is built into enterprise-wide communications, annual compliance training, educational resources, and events. Holbrook's leadership helped drive record participation in the Annual Fraud Awareness Event, with more than 17,000 employees taking part in fraud education activities. This investment helps employees understand their own role in protecting members and health care resources, extending the program's reach through an informed, engaged workforce.

The momentum carried into 2026. In the first half of the year alone, the program generated more than 6.5 million additional interactions. Ongoing articles, webinars, presentations, provider resources, member communications, and online materials show the approach is built to last. Holbrook is also developing proactive member notifications to alert individuals to emerging fraud schemes affecting their claims, building on the program's emphasis on awareness and early detection.

For other health insurers, this work offers a clear model: commit organizational resources, support dedicated leadership, build education into everyday communications, and tailor messages to the audiences who need them. NHCAA commends BCBS of Michigan Corporate & Financial Investigations and Kelly Holbrook for their complementary contributions to a far-reaching, sustainable public education effort that equips people to take a more active role in protecting themselves and precious health care resources.

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SPECIALTY BENEFITS

INVESTIGATION OF THE YEAR

National Health Care Anti-Fraud Association

# Abbott Hearing Centers

## *United States of America v. Julianna C. Lung*

The National Health Care Anti-Fraud Association proudly recognizes the investigation and prosecution teams in the case of **United States of America v. Julianna C. Lung** with the **2026 Specialty Benefits Investigation of the Year Award**.

This case, dubbed Abbott Hearing Centers, uncovered a hearing aid fraud scheme that generated nearly $1 million in improper payments from health plans participating in the Federal Employees Health Benefits Program (FEHBP). Through close cooperation among Blue Shield of California's Special Investigations Unit (SIU), the U.S. Office of Personnel Management's Office of Inspector General (OPM-OIG), and federal prosecutors, a targeted lead became a substantiated federal fraud case.

Julianna C. Lung of San Diego, CA, marketed hearing protection devices to U.S. Border Patrol agents, other federal employees, and their families, assuring customers that their insurance would cover the cost. Yet the claims she submitted billed the products as medically necessary hearing aids, with diagnoses representing that beneficiaries had hearing loss or tinnitus requiring treatment.

That distinction was central to the scheme. Consumer-grade hearing protection was presented to health plans as covered medical equipment. Targeting federal law enforcement personnel added plausibility, since occupational noise exposure could appear consistent with hearing-related diagnoses. Identifying the fraud required examining the products' actual purpose alongside the diagnoses and services reported for reimbursement.

The investigation began when OPM-OIG identified a provider and a beneficiary age range of concern and asked Blue Shield's SIU to review the associated claims. The SIU developed the lead through a coordinated review of billing patterns, member demographics, diagnosis trends, and Healthcare Common Procedure Coding System (HCPCS) utilization. The team confirmed the beneficiaries' FEHBP enrollment, established claims volume and financial impact, and revealed the discrepancy between the products marketed to members and the hearing aids represented to insurers.

This work went beyond detecting unusually high billing. By connecting product purpose, diagnosis reporting, the beneficiary population, and the reimbursement pathway, the SIU exposed a consistent pattern of misrepresentation. Its analysis linked paid claims to the specific billing mechanism underlying the fraud, helping distinguish a prosecutable scheme from isolated errors or a routine billing dispute.

The financial impact was substantial. According to Lung's plea agreement, she submitted approximately 385 fraudulent claims to FEHBP plans, which paid about $2,500 per device, roughly $962,500 in total. Blue Shield's claims analysis gave investigators a detailed view of the exposure and helped substantiate the scheme's financial consequences.

The harm extended beyond improper payments. Unsupported diagnoses of hearing loss or tinnitus could compromise the accuracy of members' medical and claims histories and affect future benefit determinations. And because hearing aid benefits are typically limited to once every three to five years, the fraudulent claims risked consuming coverage for devices that provided none of a hearing aid's benefit.

Cooperation among Blue Shield of California, OPM-OIG, and the U.S. Attorney's Office for the Southern District of California carried the case from referral through prosecution. OPM-OIG supplied the initial focus; Blue Shield's SIU defined the scope, quantified the loss, and substantiated the billing mechanism; and prosecutors brought the matter to criminal resolution. On June 25, 2026, Lung pleaded guilty in federal court to health care fraud, admitting that she sold hearing protection devices while falsely billing insurers for medically necessary hearing aids.

This case demonstrates the value of private-public collaboration in protecting specialty benefits. The partners combined a targeted federal referral, insurer claims expertise, and prosecutorial action to expose a repeatable fraud pattern and hold the perpetrator accountable. Their work also offers a practical model for investigators examining whether consumer products are being misclassified as covered medical equipment. Through their shared efforts, Blue Shield of California, OPM-OIG, and federal prosecutors strengthened the integrity of the FEHB program and helped protect the benefits entrusted to federal employees and their families.

## CONGRATULATIONS TO

**UNITED STATES DEPARTMENT OF JUSTICE**
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***Southern District of California***
**George Manahan,** *Assistant United States Attorney*

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**Lawrence Gard,** *Special Agent*

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**Bryan C. Crawley,** *Esq., Managing Associate General Counsel*
**Jonnie Massey,** *AHFI, CPC, CPC-P, CPC-I, CPMA, Senior Director*
**Brandee Perras,** *Investigator*
**Linda R. Rosal,** *AHFI Lead Investigator*
**Karyn Ross,** *Financial Investigator*
**Jennifer A. Sims,** *AHFI, CBCS, CMAA, Senior Manager*
**Susan Strand,** *CPC, Triage Analyst*

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SIRIS

INVESTIGATION OF THE YEAR

National Health Care Anti-Fraud Association

# Operation E Sizzurp

The National Health Care Anti-Fraud Association proudly recognizes the investigation and prosecution teams behind **Operation E Sizzurp** with the **2026 SIRIS® Investigation of the Year Award**. This case demonstrates the importance of private-public partnership in identifying emerging fraud schemes and coordinating an effective response.

Led by the Federal Bureau of Investigation and Drug Enforcement Administration, this multi-year investigation uncovered a nationwide operation that exploited electronic prescribing systems to divert controlled substances. Private-sector partners, including Kaiser Permanente's National Special Investigations Unit, helped identify additional victims and fraudulent prescriptions, and the NHCAA SIRIS® database contributed to the information-sharing effort.

From September 2020 through May 2023, Benjamin Jamal Washington and his co-conspirators obtained the names, dates of birth, addresses, telephone numbers, National Provider Identification (NPI) numbers, and DEA registration numbers of dozens of physicians. They used this information to obtain fraudulent driver's licenses in the physicians' names and paid corrupt telecommunications employees to perform illegal subscriber identity module, or SIM, swaps, transferring the physicians' phone numbers to phones the group controlled.

With fraudulent identification and control of the victims' phone numbers, the group circumvented verification processes and opened e-prescribing accounts in the physicians' names. At least one co-conspirator consulted a pharmacy technician to learn legitimate prescribing patterns to avoid detection. The ring submitted at least 5,600 fraudulent prescriptions for controlled substances, including oxycodone and promethazine with codeine, then traveled to pharmacies nationwide, including in the Los Angeles area, to collect the drugs and sell them for significant profit.

The case presented real challenges. Individuals collected prescriptions on behalf of others, paid in cash, and wore masks during the COVID-19 pandemic, leaving little identifying information. Fraudulent prescriptions reached pharmacies nationwide, creating overlapping investigations involving the same compromised identities. Investigators had to master the prescribing platforms and verification procedures while piecing together evidence scattered across jurisdictions.

A hallmark of Operation E Sizzurp was the sustained cooperation between Kaiser Permanente and public agencies. Kaiser Permanente's National SIU provided real-time notifications about newly identified victims and fraudulent prescriptions, bringing health care information directly into the investigation as new activity emerged.

The SIRIS® database supported this response. A SIRIS fraud scheme entry drew more than 200 member views, giving members a shared resource for tracking the emerging threat. Alongside direct communication among Kaiser Permanente, law enforcement, pharmacy boards, and other partners, the alert helped coordinate overlapping cases, showing how SIRIS complements partnerships between private-sector investigators and public agencies.

The FBI team also organized a national deconfliction meeting with the DEA's Strategic Operations Division, sharing the vulnerabilities uncovered and methods developed with teams pursuing similar cases and extending the investigation's value beyond a single case.

To reconstruct the enterprise, investigators pursued more than 30 electronic search warrants and court orders and more than 50 grand jury subpoenas. Analysis uncovered IP addresses, messages, photographs, and background reports on known victims, while facial recognition and other digital evidence helped connect the activity to Washington.

The harm extended beyond illegal drug distribution. The fraud compromised physicians' professional identities and exposed communities to diverted drugs. Fraudulent prescriptions could also enter state prescription drug monitoring programs, falsely suggesting that victimized physicians were responsible for improper prescribing.

In September 2025, Washington pleaded guilty to conspiracy to commit wire fraud, aggravated identity theft, and conspiracy to distribute controlled substances. On January 13, 2026, U.S. District Judge Wesley L. Hsu sentenced him to 65 months in federal prison.

Operation E Sizzurp exemplifies NHCAA's commitment to private-public partnership against health care fraud and abuse. The cooperation among Kaiser Permanente, national, state, and local law enforcement, and federal prosecutors—all supported by SIRIS® information sharing—demonstrates how a coordinated response can expose emerging schemes, protect legitimate providers, and bring perpetrators to justice.

## CONGRATULATIONS TO

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**Michael Davis,** *Special Agent*
**Ashley Horne,** *Special Agent*
**William Stachnik,** *Special Agent*

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**Matthew J. Tako,** *Assistant United States Attorney*
**Ian V. Yanniello,** *Assistant United States Attorney*

**HEALTH AUTHORITY LAW ENFORCEMENT TASK FORCE (HALT)**
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**Los Angeles County Sheriff's Department**
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**Douglas Herb,** *Detective*

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**Bureau of Narcotics Investigation & Drug Control**
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**Stephen J. Stahl,** *Narcotics Agent*

**KAISER PERMANENTE**
**National Special Investigations Unit**
**Mark J. Horowitz,** *RPH, Senior Manager*

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INVESTIGATION OF THE YEAR

HONORABLE MENTION

National Health Care Anti-Fraud Association

# Safe Chain Solutions

## *United States of America v. Adam Brosius, Patrick Boyd, and Charles Boyd*

The National Health Care Anti-Fraud Association is pleased to recognize the investigation and prosecution teams in the **Safe Chain Solutions** case with an **Investigation of the Year – Honorable Mention**. Their coordinated work exposed a nationwide pharmaceutical diversion scheme that endangered vulnerable patients who depended on HIV medications and undermined the integrity of the prescription drug supply chain.

The case began in April 2020, when pharmacies in multiple states reported that patients were receiving incorrect or suspicious HIV medications. The complaints prompted a joint investigation by the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG), the FBI, the Broward County (Fla.) Sheriff's Office, the Hollywood (Fla.) Police Department, the U.S. Attorney's Office for the Southern District of Florida, and the Department of Justice National Fraud Enforcement Division's Health Care Fraud Section.

Safe Chain Solutions, a Maryland pharmaceutical wholesaler, bought HIV medications at steep discounts from black-market suppliers who acquired them through patient buyback schemes. The suppliers stripped prescription labels and shipped previously dispensed bottles, many dirty, unsealed, or visibly compromised, in discarded packaging. The defendants used forged transaction statements and falsified invoices to hide the drugs' origin, mixing them with lawful inventory to mimic ordinary wholesale commerce.

Between April 2020 and September 2021, the company's owners paid more than $92.8 million for over 28,000 bottles of black-market HIV drugs and resold them to pharmacies for a profit, with Medicare, Medicaid, and commercial insurers paying for the illicit drugs. Despite repeated pharmacy complaints and concerns from the company's own compliance director, the owners continued the scheme while concealing their activities.

The harm to patients was immediate and serious. One man received a bottle labeled as his HIV medication that instead contained an antipsychotic; after unknowingly taking it, he lost consciousness for 24 hours. Another patient also ingested the wrong drug. Evidence at trial established that missing even one dose of HIV treatment can increase viral load and heighten the risk of community transmission.

Investigators faced a network designed to hide behind authentic-looking records, interstate shipments, and layered financial transactions. HHS-OIG and FBI agents worked side by side, conducting undercover purchases, reconstructing distribution pathways, and tracing financial flows. By comparing wholesale records, electronic transaction statements, and seized documents, the team identified forged documentation and showed how diverted medications entered the legitimate supply chain, while financial analysis established the conspiracy's scope and the flow of proceeds.

Cooperation among the agencies was central throughout. Sharing patient complaints, pharmacy audits, suspicious order reports, and manufacturer alerts let investigators connect evidence across jurisdictions. The Broward County Sheriff's Office supported local investigative and judicial operations, and federal prosecutors worked closely with agents to turn complex pharmaceutical and financial evidence into a clear trial presentation.

In October 2025, the two owners were convicted at trial of offenses involving misbranded drugs, false medical product documentation, and wire fraud. In March 2026, they received prison sentences of 18 and 20 years and were ordered to pay $21.85 million in forfeiture. A third defendant had earlier pleaded guilty to conspiracy to commit wire fraud and received a 97-month sentence.

The impact reached beyond the courtroom, as pharmaceutical manufacturers strengthened their investigative capabilities and improved transaction verification and tracking. The case demonstrates the value of sustained interagency collaboration: by combining specialized expertise, the teams secured accountability, disrupted a dangerous diversion network, and helped protect patients and the health care programs that serve them.

## CONGRATULATIONS TO

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**Office of Investigations**

**Carlos A. Baixauli, Jr.,** *Special Agent*
**Eddie Calienes,** *Special Agent*
**Anthony Lam,** *CFE, Special Agent*
**Nicholas A. Palino,** *Special Agent*
**Fernando Porras,** *Assistant Special Agent in Charge*
**Shibin Shaji,** *Special Agent*
**Malik A. Williams,** *Special Agent*
**Cesar Zayas,** *Special Agent*

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**Federal Bureau of Investigation**

**Lynnette Alvarez-Karnes,** *Supervisory Special Agent*
**Daniel Conger,** *CFE, EA, Forensic Accountant*
**Lauren Roig,** *Special Agent*
**Daniel Rosenberger,** *Special Agent*
**Albert Paul Stewart,** *Special Agent*

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**Health Care Fraud Section**

**Steven A. Aponte,** *Senior Paralegal*
**Jamie de Boer,** *Assistant Chief*
**Mitchell Hyder,** *Senior Paralegal*

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**United States Attorney's Office**
**Southern District of Florida**

**Jacqueline Z. DerOvanesian,** *Assistant United States Attorney*
**Alexander Thor Pogozelski,** *Assistant United States Attorney*

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National Health Care Anti-Fraud Association

# Done ADHD

## *United States of America v. Ruthia He & David Brody*

The National Health Care Anti-Fraud Association is honored to recognize the investigative and prosecutorial teams behind the **Done ADHD** case with the **2026 Investigation of the Year Award**. Their remarkable, coordinated work exposed a nationwide scheme that exploited the use of telemedicine to unlawfully distribute controlled substances, defraud health care programs, and endanger patients. This case, **USA v. Ruthia He & David Brody**, demonstrates the strength of federal investigative and prosecutorial cooperation, supported by private-sector vigilance and sustained information sharing.

Done Global, Inc., a California-based digital health company, promoted convenient access to attention deficit hyperactivity disorder (ADHD) treatment through a monthly subscription model. As telemedicine expanded during the COVID-19 pandemic, its executives used the company's platform, compensation structure, and clinical policies to put prescription volume and revenue ahead of medical necessity. The scheme unlawfully distributed more than 37 million Adderall pills and caused Medicare, Medicaid, and commercial insurers to pay more than $12 million for prescription drugs.

The defendants spent more than $40 million on social media advertising. Clinicians were pressured to diagnose ADHD in brief appointments and prescribe stimulants to patients they believed did not have ADHD or they faced serious risks. Those who resisted were refused employment or fired, while some compliant clinicians earned up to $60,000 a month. An automated renewal feature allowed patients to obtain prescriptions without meaningful follow-up, sometimes for years.

In 2022, the Special Investigations Unit of Evernorth Health Services, a division of the Cigna Group, used pharmacy claims analytics at Express Scripts to flag unusually high volumes and rapid prescribing of Schedule II stimulants among Done-affiliated providers. Provider outreach uncovered practices that claims data alone could not explain. Beginning in 2023, the team shared its findings, including information on nearly 100 potentially associated prescribers, with the Department of Justice's Health Care Fraud Strike Force and continued coordinating with prosecutors as the case advanced.

The federal investigation brought together the Drug Enforcement Administration, the HHS Office of Inspector General, Homeland Security Investigations, and IRS Criminal Investigation, working with prosecutors from the Department of Justice's Health Care Fraud Section and the U.S. Attorney's Office for the Northern District of California. Agents in California and New York pursued evidence across multiple states.

Undercover recordings of patient intake revealed how Done's model actually worked. Subpoenas, search warrants, and seized devices produced emails, Slack messages, medical records, advertisements, and patient discharge requests, while Zoom records showed that appointments were inadequately brief or never occurred. This evidence tied the company's technology, pay incentives, and directives to unlawful prescriptions and fraudulent reimbursement, implicating the executives who directed clinical operations.

False prior authorization requests claimed that diagnostic criteria had been followed, drug screens performed, and non-stimulant treatments tried. When pharmacies questioned or blocked prescriptions, the defendants misrepresented Done's compliance safeguards. The founder also obstructed justice by moving operations overseas, directing employees to encrypted messaging, and deleting incriminating records.

The harm went beyond financial losses. Patients kept receiving stimulants despite warnings about serious psychiatric conditions, and at trial, mothers described failed efforts to stop prescriptions that endangered their children.

In November 2025, a federal jury convicted both executives of conspiracy to distribute controlled substances, unlawful distribution, and conspiracy to commit health care fraud; the founder was also convicted of conspiracy to obstruct justice. In July 2026, the founder and former clinical president were sentenced to six and two years in prison, respectively, and each was fined $1 million.

This case shows the strength of private-public partnership: federal agencies and prosecutors secured accountability, supported by Evernorth's analysis and cooperation, offering a compelling model for confronting fraud as health care delivery evolves.

## CONGRATULATIONS TO

**UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES**
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**Zachary A. Toner,** *Special Agent*

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**James Bowers,** *Business Analytics Senior Manager*
**Jeffrey A. Jasso,** *Senior Fraud Manager*
**Mark L. Krieger,** *Business Analytics Senior Advisor*

# Other Notable Nominations

### MULTI-MILLION-DOLLAR MEMBER SUBMITTED FOREIGN CLAIMS

Blue Shield of California investigators examined 28 foreign medical claims totaling more than $80 million, including purported same-day outpatient organ transplants. Reviews uncovered reused records, publicly available medical images, conflicting travel information, and procedures inconsistent with accepted medical practice. Careful claim-by-claim verification and coordination across departments prevented more than $75 million in improper payments and protected the integrity of the plan's international claims program.

### OPERATION HOSPICE INTEGRITY

In response to a surge of suspicious hospice claims in Los Angeles County, Blue Shield of California teams investigated allegations involving services not rendered, non-terminally ill enrollees, and phantom providers. Investigators, analysts, and payment integrity staff coordinated referrals, medical record reviews, prepayment scrutiny, and stop-payment actions. These efforts produced approximately $5.67 million in combined savings and cost avoidance while strengthening fraud detection and reporting procedures.

### OPERATION NIGHTINGALE PHASE II

Operation Nightingale exposed a South Florida network that sold approximately 15,000 fraudulent nursing credentials for an estimated $250 million, allowing some purchasers to obtain licenses and work without completing required training. Phase II advanced prosecutions involving fraudulent diplomas and transcripts. Across the investigation, 43 defendants were convicted, numerous schools were closed, and substantial forfeitures were ordered. The case highlighted serious patient-safety risks associated with fraudulent professional credentials.

### PHANTOM PROVIDERS

Clover Health responded to a coordinated surge of claims from hundreds of suspected phantom providers, many using compromised patient information. Investigators combined claims screening, provider verification, dark-web intelligence, and risk analysis to identify suspicious billing, particularly in laboratory and durable medical equipment services. The team placed claims on hold, denied questionable submissions, and referred information involving more than 1,000 providers to federal investigators, strengthening protections against rapidly evolving provider-identity fraud.

### THE PEOPLE OF THE STATE OF CALIFORNIA VS. HISMATULLIN ET AL. (ACTION URGENT CARE)

A two-year investigation into Action Urgent Care exposed alleged COVID-era upcoding, telemedicine fraud, and unlawful corporate practice of medicine. Collaboration between Santa Clara County investigators and health insurers, supported by information shared through SIRIS®, led to the seizure of cryptocurrency assets and $8.4 million in immediate restitution --the largest medical insurance fraud recovery in the District Attorney's Office history. The lead defendant was convicted of unlawful corporate practice of medicine.

### UNITED STATES OF AMERICA V. BRETT BLACKMAN

Executives of HealthSplash operated a digital platform that facilitated fraudulent prescriptions for orthotic braces and pain creams through telemarketing, telemedicine, pharmacies, and durable medical equipment suppliers. The nationwide conspiracy generated more than $1 billion in fraudulent claims and over $450 million in payments from federal health care programs. The prosecution held accountable the technology-company executives who helped organize and conceal the scheme, rather than only the businesses submitting claims.

### UNITED STATES OF AMERICA V. CORY LLOYD AND STEVEN STRONG

An investigation uncovered fraudulent enrollment of tens of thousands of vulnerable consumers in fully subsidized Affordable Care Act health plans, generating commissions for insurance and marketing businesses. The scheme involved more than $233 million in improperly obtained subsidies, of which the government paid over $180 million. Some consumers experienced disruptions to Medicaid coverage and necessary care. Convictions of Cory Lloyd and Steven Strong highlighted both the financial and patient consequences of enrollment fraud.

### UNITED STATES OF AMERICA V. HEREK

Investigators dismantled a multistate Medicare Advantage fraud scheme involving more than 29 interrelated companies, deceptive call centers, and medically unnecessary orthotic braces. The operators used misleading beneficiary outreach, telemedicine orders, and disguised kickback arrangements to submit more than $34 million in false claims and obtain approximately $17.6 million in payments. Financial tracing and reconstruction of the corporate network helped expose the operation and protect older beneficiaries.

### UNITED STATES OF AMERICA V. HERTZBERG, ET AL.

A federal investigation uncovered a multistate kickback conspiracy involving rural hospitals, an affiliated laboratory, referring physicians, marketers, and executives. Payments disguised as investment returns encouraged referrals and the ordering of laboratory services. Following a demanding seven-week trial involving extensive testimony and documentary evidence, five hospital and laboratory executives were convicted. The case demonstrated the importance of pursuing those who organize and profit from improper referral arrangements.

### UNITED STATES OF AMERICA V. VIOLETTA MAILYAN

Data analysis uncovered a Medicare Botox billing scheme operated by a California physician who billed for cosmetic injections as medically necessary migraine treatment and claimed services on days she was absent or her office was closed. Investigators identified more than $45 million in claims and over $32 million in Medicare payments. In May 2026, Violetta Mailyan was convicted on 12 federal counts, demonstrating the value of data-driven investigations and coordinated federal enforcement.

*See more* ▶

# Other Notable Nominations

### CMS FRAUD DEFENSE OPERATIONS CENTER (FDOC) TEAM

Known as the "Medicare Fraud War Room," the CMS Fraud Defense Operations Center combines advanced analytics, real-time payment screening, and rapid collaboration among program experts, investigators, and law enforcement to identify suspected fraud before payments are made. Its work has exposed questionable hospice billing and durable medical equipment claims for supplies beneficiaries never ordered or received. By identifying emerging schemes and sharing findings, the team helps protect Medicare funds, beneficiaries, and public trust.

### FBI SAN DIEGO HEALTH CARE AND ELDER FRAUD OUTREACH TEAM

FBI San Diego combined health care fraud and elder fraud prevention presentations to reach older adults with practical guidance on recognizing schemes, safeguarding personal information, and reporting suspected fraud. The team also developed a health care fraud awareness brochure approved by FBI Headquarters for use by field offices nationwide. The initiative has generated investigative leads and expanded access to consistent, proactive fraud prevention education.

### JENEEN IWUGO, ACTING DIRECTOR, CMS-CPI

As Acting Director of the Center for Program Integrity at CMS, Jeneen Iwugo leads efforts to prevent fraud, waste, and abuse across Medicare, Medicaid, and the Health Insurance Marketplace. Her work encompasses Medicare provider enrollment oversight, Medicaid program integrity, Medicare Advantage risk-adjustment audits, and efforts to address agent and broker misconduct in the Marketplace. Through public engagement and discussion of emerging fraud-prevention technologies, she has helped bring attention to the importance of program integrity.

### LUBBOCK FIELD OFFICE, TEXAS MEDICAID FRAUD CONTROL UNIT – SANCHEZ CASE

A joint investigation revealed that Judy Sanchez obtained more than $227,000 in Medicaid payments intended to provide care for her severely disabled adult son while he suffered prolonged neglect. Investigators pursued the financial fraud and allegations of abuse together, exposing the human consequences of diverted care funds. Sanchez received a 17-year federal prison sentence and was ordered to pay restitution. The case underscores that health care fraud can directly threaten the safety and dignity of vulnerable patients.

# AWARDEE CONFERENCE SESSIONS

## OPERATION E SIZZURP

*The recipients of NHCAA's 2026 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.*

*"Digital Prescriptions, Real Crimes: Unmasking Fraud in Modern Prescribing"*

Thursday, November 5, 2026
1:30 PM – 2:30 PM
Town and Country Ballroom A
Town and Country Resort

## ABBOTT HEARING CENTERS

***United States of America v. Julianna C. Lung***

*The recipients of NHCAA's 2026 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 5, 2026
2:45 PM – 3:45 PM
Town and Country Ballroom A
Town and Country Resort

## DONE ADHD

***United States of America v. Ruthia He & David Brody***

*The recipients of NHCAA's 2026 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 6, 2026
8:30 AM – 10:30 AM
Town and Country Ballroom C
Town and Country Resort

***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.*




National Health Care Anti-Fraud Association
1220 L Street, NW
Suite 815
Washington, DC 20005

**Phone:** 202.659.5955
**Web:** www.nhcaa.org