

**Department of Justice**

U.S. Attorney's Office

Central District of California

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**25 Southern California Defendants Face Federal Charges  
Alleging Fraud Schemes that Cost Health Care Programs  
Millions of Dollars**

*LOS ANGELES* – A local health care fraud enforcement action has resulted in federal charges against of 25 Southern California defendants for their alleged involvement in healthcare fraud schemes that fraudulently sought over \$150 million from the Medicare and Medicaid programs, as well as private insurers and union health benefit plans. Fourteen of those charged in federal court in Los Angeles and Santa Ana are doctors or medical professionals.

The charges announced today target schemes billing Medicare, Medicaid and other health care plans for services, testing and prescriptions that were not medically necessary or not actually provided to beneficiaries.

The cases announced today are the result of investigations being conducted by the Federal Bureau of Investigation; the U.S. Department of Health and Human Services, Office of the Inspector General (HHS-OIG); the U.S. Department of Labor, Office of Inspector General; the U.S. Department of Labor, Employee Benefits Security Administration; the Defense Criminal Investigative Service; the Amtrak Office of Inspector General; the U.S. Office of Personnel Management, Office of Inspector General; the California Department of Insurance; and the California Department of Justice.

The criminal cases have been brought by the United States Attorney's Office and prosecutors in the Health Care Fraud Unit of the Criminal Division's Fraud Section at the Justice Department who work with law enforcement partners under the aegis of the Medicare Fraud Strike Force.

"Corruption drains dollars from private insurers and public programs such as Medicare and Medicaid," said United States Attorney Nick Hanna. "This office will continue to hold accountable anyone – including medical professionals – who seeks to bilk our nation's health care system."

"Today's action shows that our ability to detect and prosecute health care fraud grows more sophisticated with each passing day," said Assistant Attorney General Brian A. Benczkowski of the Justice Department's Criminal Division. "The Department of Justice is using every tool at our disposal to target the medical professionals and others who place their personal greed above the public good."

"Sticking taxpayers with a bill for unnecessary healthcare services will never be tolerated," said Special Agent in Charge Timothy B. DeFrancesca of the U.S. Health and Human Services, Office of the Inspector General. "Working closely with our law enforcement partners, our agency will tirelessly pursue physicians and others who threaten the integrity of Federal healthcare programs."

"Health care fraud schemes cheat American taxpayers and healthcare programs out of millions of dollars," said Assistant Director in Charge Paul D. Delacourt of the FBI's Los Angeles Division.

“With the assistance of the public, the FBI and partner agencies will continue to combat this unscrupulous criminal activity that seeks to financially exploit our healthcare system.”

“Criminal activity that drives up medical costs for Californians at the expense of vulnerable communities will not be tolerated,” said California Attorney General Xavier Becerra. “The California Department of Justice will continue to seek opportunities to work with our federal partners to not only prevent wrongdoing, but also target fraudsters and hold them accountable.”

A total of 10 cases are being announced today. Those charged are:

- Dr. Ronald Weaver, 70, of Pacific Palisades; Sara Soulati, 49, of Santa Monica; Dr. John Weaver, 75, of Alhambra; Dr. Ronald Carlish, 78, of Pacific Palisades; Dr. Howard Elkin, 68, of Whittier; Dr. Wolfgang Scheele, 79, of Los Angeles; and Dr. Nagesh Shetty, 74 of Huntington Beach, who were charged for their alleged participation in an approximately \$135 million scheme to defraud Medicare through medically unnecessary cardiac treatments and testing through Global Cardio Care of Inglewood. This case is being prosecuted by DOJ Trial Attorneys Emily Z. Culbertson and Alexandra Michael.
- Navid Vahedi, 40, of Los Angeles; Vahedi’s pharmacy, Fusion Rx Compounding Pharmacy; and Joseph S. Kieffer, 39, a marketer, of Los Angeles, who were charged in a fraud and kickback scheme. Vahedi and Kieffer, allegedly paid commissions to marketers and some patients to obtain medically unnecessary compounded drugs to allow Fusion Rx to bill health care providers for those compounded drugs, many of which were reimbursed at rates much higher than average medications. To encourage patients to continue seeking the compounded drugs, Fusion Rx allegedly failed to collect copayments from patients. However, to avoid the scheme being uncovered in an audit, they also allegedly directed Fusion Rx staff to use gift cards to pay the patients’ copayments for them so that it would appear they made the required copayments. This conduct allegedly resulted in approximately \$17 million in losses to health care providers, while the defendants spent substantial sums of money on themselves, including Vahedi’s purchase of a 1963 Ford Mustang Cobra. Also charged in a related case was Joshua Pearson, 40, a marketer, of St. George, Utah, for his alleged receipt of illegal kickbacks from Fusion Rx, Vahedi and Kieffer for patient referrals for compounded drugs (Pearson is a 26<sup>th</sup> defendant in the cases being announced today). The cases are being prosecuted by Assistant United States Attorneys Ashwin Janakiram and Alexander Schwab of the Major Frauds Section and Assistant United States Attorney Jonathan Galatzan of the Asset Forfeiture Section.
- Hilda Haroutunian, 59, of Sun Valley; Dr. Keyvan Amirikhorheh, 60, of Seal Beach; Lorraine Watson, 56, a physician’s assistant, of Valley Village; Noem Sarkisyan, 63, of North Hollywood; and Edmond Sarkisyan, 40, a medical assistant, of North Hollywood, who were charged for their alleged participation in an approximately \$10 million scheme to defraud the Family Planning, Access, Care and Treatment (Family PACT) program administered by Medi-Cal, the California Medicaid program, through fraudulent claims for family planning services, testing and prescriptions for non-existent patients submitted through Los Angeles Community Clinic and associated diagnostic testing

laboratories and pharmacies. The case is being prosecuted by DOJ Trial Attorney Alexis D. Gregorian.

- Amir Friedman, 54, an anesthesiologist, of Calabasas, who is charged for his alleged participation in a conspiracy to commit honest services mail and wire fraud and Travel Act violations involving approximately \$800,000 in kickbacks for compounded pharmaceutical drugs involving New Age Pharmaceuticals, Inc., in Beverly Hills. The case is being prosecuted by Assistant United States Attorney Ashwin Janakiram.
- Susan H. Poon, 54, a chiropractor who resides in Dana Point, who was arrested today after a federal grand jury charged her in an approximately \$2 million scheme to defraud Anthem, Aetna, and other Blue Cross Blue Shield Association affiliates, including the Teamsters Western Region and Local 177 health care plans. Through this scheme, Poon allegedly submitted false and fraudulent claims for chiropractic services never provided, medical diagnoses never given, and office visits that never occurred. Poon also allegedly submitted false and fraudulent prescriptions to a provider of durable medical equipment that relied on those false prescriptions in its reimbursement claims. Employees and employee-dependents of the United Parcel Service and Costco Wholesale Corporation, who allegedly never received the claimed services or sought the claimed medical equipment, were named as patients in Poon's false claims and prescriptions. The case is being prosecuted by Assistant United States Attorney Daniel S. Lim of the Santa Ana Branch Office.
- Antonio Olivera, 78, of Downey; Emelita Cephass, 57, of Downey; and Martin Canter, 70, of Rancho Palos Verdes, who were charged for their alleged participation in a hospice kickback scheme. Olivera was also charged for his alleged participation in a scheme to defraud Medicare. Both schemes involve Mhiramarc Management LLC, a hospice located in Downey. In a separate case, hospice owner John O'Brien was charged with health care fraud conspiracy for his alleged role in the fraud scheme. The cases are being handled by DOJ Trial Attorney Justin P. Givens.
- Mahyar David Yadidi, 37, a chiropractor who resides in Los Angeles, who was charged with conspiracy to commit health care fraud for operating a scheme to defraud the International Longshore and Warehouse Union – Pacific Maritime Association health care benefit plan. Yadidi allegedly defrauded the ILWU-PMA Plan through his chiropractic clinic, San Pedro Philips Chiropractic, by offering kickbacks to patients for attending the clinic and by billing the benefit plan for services that were not rendered to its patients, services that were not medically necessary, and services that were provided by unlicensed employees not qualified to perform them. Yadidi allegedly continued to operate his scheme after he was terminated as an authorized provider by the ILWU-PMA plan. Ivan Semerdjiev, 40, of Irvine, a chiropractor working for Yadidi, and Julian Williams, 44, of San Pedro, a personal trainer working for Yadidi, were also charged in connection with this fraud conspiracy. In total, Yadidi, Semerdjiev and Williams submitted almost \$5 million in claims to the ILWU-PMA plan. The case is being prosecuted by Assistant United States Attorney Alex Wyman.

- Darren Hines, 49, a chiropractor who lives in the Harbor City neighborhood of Los Angeles, who was charged with health care fraud for operating a scheme to defraud the International Longshore and Warehouse Union – Pacific Maritime Association health care benefit plan. Hines allegedly defrauded the ILWU-PMA plan through his chiropractic clinic, Advanced Alternative Health, by billing for services not rendered and services being provided by unlicensed employees who were not qualified to perform them, all after Hines was terminated as an authorized provider by the ILWU-PMA plan. Hines allegedly submitted over \$500,000 in fraudulent claims over a short period of time. The case is being prosecuted by Assistant United States Attorney Alex Wyman.

“Health plans are tempting targets for unscrupulous individuals,” said Crisanta Johnson, Los Angeles Regional Director for the U.S. Department of Labor’s Employee Benefits Security Administration. “When wrongdoers victimize health plans and their participants, EBSA and its fellow enforcement agencies will take prompt, aggressive, and coordinated action to hold them accountable.”

Thomas W. South, Deputy Assistant Inspector General for Investigations, the U.S. Office of Personnel Management, Office of Inspector General, said: “I am proud of the outstanding work of the OPM OIG investigative staff and our law enforcement partners. The OPM OIG has zero tolerance for unethical behavior and we will vigorously investigate cases of fraud and abuse by professionals in the health care industry.”

“An important mission of the Office of Inspector General is to investigate allegations of fraud relating to labor unions and their affiliated employee benefit plans. We will continue to work with our law enforcement partners to investigate these types of allegations,” said Quentin Heiden, Acting Special Agent-in-Charge, Los Angeles Region, U.S. Department of Labor, Office of Inspector General.

“Our office, in partnership with our fellow investigative agencies, will continue to comprehensively investigate and bring to justice the people who perpetrate health care fraud,” said Kevin Winters, Amtrak’s Inspector General. “We will remain vigilant in protecting Amtrak employees, retirees, and their dependents, by ensuring our health care dollars are not wasted on fraudulent providers.”

*The charges and allegations contained in the indictments are merely accusations. The defendants are presumed innocent until and unless proven guilty.*

The Justice Department’s Fraud Section leads the Medicare Fraud Strike Force, which is part of a joint initiative between the Department of Justice and HHS to focus their efforts to prevent and deter fraud and enforce current anti-fraud laws around the country. There are 15 strike forces operating in 24 federal districts, and, since its inception in March 2007, strike force prosecutors have charged nearly 4,000 defendants who have collectively billed the Medicare program for more than \$14 billion. In addition, HHS Centers for Medicare & Medicaid Services, working in conjunction with HHS-OIG, are taking steps to increase accountability and decrease the presence of fraudulent providers.

The U.S. Department of Labor, Office of Inspector General is responsible for identifying and reducing labor racketeering and corruption in employee benefit plans, labor-management relations, and internal union affairs. Through its criminal investigations and collaboration with the Employee Benefits Security Administration and other federal law enforcement partners, the DOL-OIG works diligently to ensure prosecution of individuals involved in wrongdoing related to union affairs.

The U.S. Department of Labor's Employee Benefits Security Administration is responsible for protecting the retirement, health and other workplace-related benefits of America's workers and their families. As part of its overall enforcement program, EBSA investigates criminal acts committed against employer- and union-sponsored health and welfare plans in coordination with other law enforcement partners.