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CLIENT ALERT
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Feds Charge 138 in Health Care Fraud Schemes Estimated at $1.4 Billion

Last week the Department of Justice (DOJ) announced that it had charged 138, including a number of doctors, nurses, and other medical professionals, for their alleged participation in a number of health care fraud schemes. Losses to both federal health care programs and private insurance programs are estimated at nearly $1.4 billion.

The schemes fell into several categories, including telemedicine fraud, COVID-19 fraud, so called "sober home" cases, and opioid/illegal prescription and general health care fraud cases.

By far the largest category of fraud involved telemedicine. Over $1.1 billion in fraud cited by DOJ involved false and fraudulent telemedicine claims. In some instances, medical professionals submitted claims for telemedicine visits that never occurred, or which did not occur as represented. In others, telemedicine executives allegedly paid doctors and nurse practitioners to order unnecessary tests, pain medications, and durable medical equipment for patients that they had never seen or had only brief telephone contact with. The scheme continued when pharmacies, durable medical equipment companies and labs "purchased" the fraudulent orders in exchange for illegal kickbacks. Funds received from the fraud were spent on luxury vehicles, yachts, and real estate.

Fourteen defendants were charged in schemes related to the COVID-19 pandemic and the various polices that were enacted to expand access to care or to provide relief funds. In these cases, the fraudulent schemes included the submission of fraudulent claims to the Provider Relief Fund (part of the CARES Act) and the misuse of patient information which was ultimately used to submit claims to Medicare for unnecessary and expensive laboratory testing. The defendants used the ill-gotten gains from these claims for trips to Las Vegas and luxury vehicles. This batch of arrests follows a similar takedown of 14 defendants made in May of 2021. In those cases, over $128 million in false billings were submitted through various COVID-19 relief programs.

In the "sober homes" cases, over $133 million in false and fraudulent claims were submitted in illegal kickback and bribery schemes that involved the referral of patients to substance abuse facilities. Fraudulent claims for unnecessary drug testing and therapy sessions were submitted to multiple private insurers.

In the “run of the mill” health care fraud category, the federal dragnet netted nearly 80 additional defendants who allegedly submitted false and fraudulent claims to Medicare, Medicaid, TRICARE, and private insurance companies for treatments that were medically unnecessary or never provided. These schemes are estimated to have cost federal and private providers over $145 million. Additionally, a number of health care providers were charged for prescribing over 12 million doses of opioids and submitting over $14 million in false billings for those prescriptions.

The FisherBroyles Pharmacy and Health Care Law team is pleased to keep you updated on events of interest to those in the healthcare, medical device, and pharmaceutical industries. Questions related to the subject matter of this alert may be directed to any of following attorneys.

Brian E. Dickerson
brian.dickerson@fisherbroyles.com
202.570.0248

Anthony J. Calamunci
Anthony.calamunci@fisherbroyles.com
419.376.1776

Office address: 625 Tamiami Trail North, Suite 203, Naples, FL 34102

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