STRATEGIC MANAGEMENT SERVICES

DOJ Charges 78 Defendants For $2.5 Billion in Healthcare Fraud

Richard P. Kusserow | July 2023

Key Points:

- **$2 billion in fraudulent claims resulted from telemedicine schemes**
- **Other actions involve prescription drugs and the illegal distribution of opioids**

DOJ recently announced it was charging 78 defendants for their alleged participation in a $2.5 billion health care fraud and opioid abuse schemes impacting the elderly and disabled. Some of the proceeds of the schemes were then used to purchase luxury items, including exotic automobiles, jewelry, and yachts. The defendants resided in multiple states and are accused of participating in various schemes to defraud patients and federal healthcare programs. The schemes included telemedicine fraud, pharmaceutical fraud, and illegal opioid distribution. The schemes also involved overcharging vulnerable groups, like elderly patients, and using fraudulent prescriptions. The enforcement action also included charges against 11 defendants concerning submissions of over $2 billion in fraudulent claims resulting from telemedicine schemes. The elderly and disabled patients were targeted with direct mail, television advertisements, and other forms of advertising to induce them to contact offshore boiler rooms staffed by individuals who "up-sold" them unnecessary medical equipment and prescriptions. This was a conduit for these telemarketers to coordinate the payment of illegal kickbacks and bribes to telemedicine companies to obtain doctors' orders for Medicare beneficiaries. A software platform was programmed to generate false and fraudulent orders for telemedicine practitioners to sign and obstruct Medicare investigations by concealing that the interactions with beneficiaries had occurred remotely using telemedicine. The program-generated orders falsified certifications and diagnostic testing that Medicare required. The falsified certifications provided that the telemedicine doctors had examined the beneficiaries in person.

Ten defendants were charged, in connection, with the submission of over $370 million in fraudulent claims submitted in connection with prescription drugs. In one case, the owner and

corporate officer of a pharmaceutical wholesale distribution company was charged for an alleged $150 million fraud scheme in which the company purchased illegally diverted prescription HIV medication and then marketed and resold the medication by falsely representing that the company acquired it through legitimate channels. The defendant allegedly purchased the diverted medication at a substantial discount from individuals who obtained the drugs primarily through illegal "buyback" schemes. They paid HIV patients cash for their expensive HIV medication and repackaged them for resale. The defendant and others falsified labeling and product tracing documentation to make it appear legitimate. Pharmacies purchased the misbranded medications, dispensed them to patients, and billed them to health care benefit programs. Other charges involved over $150 million in other false billings, including the illegal distribution of opioids and clinical laboratory testing fraud. Twenty-four physicians and other licensed medical professionals were charged with putting their patients at risk by illegally providing them with opioids they did not need. The charges also include cases where healthcare companies, physicians, and other providers paid cash kickbacks to patient recruiters and beneficiaries in return for patient information so that the providers could submit fraudulent bills for Medicare reimbursement.

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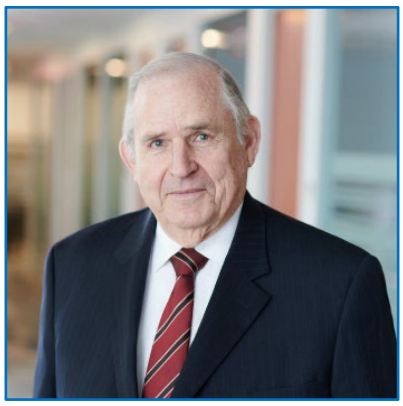

About the Author

Richard P. Kusserow established Strategic Management Services, LLC, after retiring from being the DHHS Inspector General, and has assisted over 2,000 health care organizations and entities in developing, implementing and assessing compliance programs.