

2020 National Health Care Fraud TAKEDOWN



The Department of Health and Human Services Office of Inspector General, along with our state and federal law enforcement partners, participated in a nationwide health care fraud takedown in September 2020.

SCOPE

The takedown focused on several schemes to include alleged telefraud, or scams that leverage aggressive marketing and so-called telehealth services to commit fraud. This fraudulent activity resulted in charges for **345 defendants** in **51 judicial districts**, including telemedicine executives, the owners of durable medical equipment (DME) companies, genetic testing laboratories, pharmacies, and more than **100 medical practitioners**, for their alleged participation in health care fraud schemes involving **more than \$6 billion in alleged loss**. In addition, federal health care billing privileges were revoked for **256 medical professionals** for their involvement in the schemes. Federal and state law enforcement personnel took part in this operation, including **175 OIG special agents**.

The largest amount of alleged fraud loss charged in connection with the cases announced – **\$4.5 billion in allegedly false and fraudulent claims submitted by more than 86 criminal defendants in 19 judicial districts** – relates to schemes involving

telemedicine: the use of telecommunications technology to provide health care services remotely.

TELEFRAUD SCHEME

Since 2016, HHS OIG has seen a significant increase in telefraud. The alleged scheme involves a marketing network that lured **hundreds of thousands of unsuspecting individuals** into a criminal scheme through telemarketing calls, direct mail, television advertisements, and internet pop-up advertisements. The defendant telemedicine executives allegedly paid medical practitioners to order unnecessary durable medical equipment, genetic and other diagnostic testing, and medications, either **without any patient interaction or with only a brief telephonic conversation with patients they had never met or seen**. Often, the durable medical equipment, test results, or medications were not provided to the beneficiaries or were worthless to the patients and their actual primary care doctors, and the misdirection, fake diagnoses, and unneeded tests misled patients and **delayed their chance to seek appropriate treatment for medical complaints**. The proceeds of the fraudulent scheme were allegedly laundered through international shell corporations and foreign banks for the benefit of the defendants.

The Medicare Fraud Strike Force, a joint initiative between the Department of Justice and Health and Human Services, works to prevent and deter fraud and enforce current anti-fraud laws around the country. In addition, the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services, working in conjunction with the Health and Human Services Office of Inspector General, are taking steps to increase accountability and decrease the presence of fraudulent providers.

2020 National Health Care Fraud TAKEDOWN By The Numbers

345 Defendants Charged, Including

100+ Licensed Medical Professionals

51 Judicial Districts

175 HHS-OIG Agents & Analysts

\$6+ Billion in Alleged Losses

Source: DOJ and HHS OIG