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# Telehealth execs face fraud charges surrounding COVID

ALEX KACIK


AP

Federal prosecutors have charged 14 telehealth executives, physicians, marketers and healthcare business owners for their alleged schemes that led to more than $143 million in fraudulent COVID-19-related Medicare claims, the U.S. Justice Department announced Wednesday.

Eleven individuals face new charges and three have superseding indictments, federal officials said.

CMS' Center for Program Integrity separately announced penalties for more than 50 medical providers who used telehealth to exploit patients and the government during the pandemic.

It is unquestionable that the rapid expansion of telehealth has given criminals access to a whole new pool of victims, said Mark Silberman, chair of Benesch's white collar, government investigations and regulatory compliance practice group. But the medium has also significantly increased access to care to those who would otherwise be hard to reach, he said.

"I hope the government maintains its aggressive actions against those who are out there to abuse the system. I equally hope that it doesn't limit access to appropriate telehealth utilization and further harm the victims of these offenses by denying them more access to care," Silberman said. "The answer is in well designed and thoughtful regulations—there's an abundance of providers who are happy to participate under that design."

The telehealth-related fraud charges only amount to $550,000 in alleged false claims, a fraction of the total sum appropriately spent on telehealth services for Medicare beneficiaries during COVID-19, said the Alliance for Connected Care, which represents telehealth companies.

"No federal regulator or oversight body has yet issued a comprehensive study of telehealth claims during the pandemic, yet the agencies continue to send out charged statements with misleading headlines," the alliance said in a statement. "The reality is that the majority of instances of fraud highlighted by DOJ today in its '2021 National COVID-19 Health Care Fraud Takedown' have nothing to do with telehealth."

Multiple defendants allegedly misused saliva or blood samples to bill Medicare for unrelated, unnecessary and more expensive lab tests like genetic testing. The COVID-19 tests weren't even reliable, officials claimed. Meanwhile, others offered bribes in exchange for referrals or unnecessary tests.

Another set of charges are related to the misuse of COVID-19 relief funds.

"It's clear fraudsters see the COVID-19 pandemic as a money-making opportunity—creating fraudulent schemes to victimize beneficiaries and steal from federal health care programs," Gary Cantrell, deputy inspector general for investigations at HHS' Office of Inspector General, said in **prepared remarks**.

A number of telehealth-related waivers were implemented during the COVID-19 emergency. Providers praised the regulatory easing that allowed them to reach more patients amid statewide shutdowns, but regulators also worried that they could **spur more fraud**.

CMS broadened the types of services it will reimburse when administered via telehealth. Federal officials relaxed privacy guardrails that restricted what devices can be used to administer telehealth services. They also waived patient deductibles and copayments, which otherwise would be construed as a kickback if it led to unnecessary services.

This, in part, has opened the door to more **bogus or unnecessary testing**, equipment orders and prescriptions. In some cases, telehealth companies either allegedly did not contact patients or had limited phone conversations, and durable medical equipment manufacturers, genetic testing labs and pharmacies would purchase those orders in exchange for kickbacks and bribes.

"You have to balance the benefits of telehealth against the abuse that was conducted in this forum," Silberman said. "Don't vilify the forum, vilify the criminals."

More than 340 individuals were **charged** in September with submitting $6 billion in fraudulent claims—$4.5 billion of which was related to telehealth—to federal healthcare programs and private insurers for telehealth consultations and substance abuse treatment. Although some experts questioned the scope of the "take down," claiming that some of those alleged $6 billion in fraud claims were "add-ons" from 2019 indictments.

"There's a perception that at times the political appointees feel a great deal of pressure to say they held the industry accountable, particularly during these tough times when a lot of people have had adverse health impacts," Robert Salcido, an Akin Gump partner, told Modern Healthcare last year.

The DOJ **recovered** more than $1.8 billion from healthcare-related False Claims Act settlements in 2020, marking the first time in more than a decade that they failed to clear $2 billion in returns. The $6 billion fraud take down will be included in the 2021 fiscal year.



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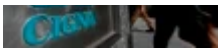

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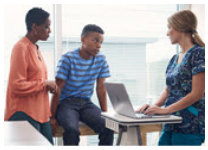

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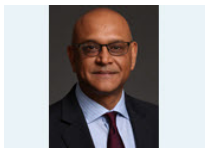

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