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Top 8 healthcare fraud cases related to COVID

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So far the Department of Justice has charged 14 defendents for alleged connections to fraud schemes taking advantage of the COVID-19 pandemic.

Dozens of healthcare workers, executives and medical business owners have faced charges or other consequences for their involvement in fraud schemes related to COVID-19 and abuse of programs designed to facilitate access to medical care during the pandemic.

The most recent charges allege a laboratory operator submitted $88 million in fraudulent claims. He and other individuals gained funds they then used to purchase items like exotic automobiles and luxury real estate, according to the U.S. Department of Justice on Thursday.

Currently, the Department of Justice is involved in nine cases of COVID-19 healthcare fraud, which are ranked below by financial scope.

1. Billy Joe Taylor, the owner and operator of Vitas Laboratories in Arkansas and Beach Tox in California allegedly was involved in a $88 million scheme where he submitted fraudulent claims for tests that were not ordered or performed, including respiratory pathogen panel and COVID-19 tests. Hundreds of claims submitted were for deceased beneficiaries and those no longer providing samples, according to the complaint.

The charges against the following defendents were first revealed on May 26.

2. Michael Stein, owner and operator of the consulting company 1523 Holdings, and Leonel Palatnik, owner of Panda Conservation Group and its Texas testing laboratories, were charged related to an alleged $73 million conspiracy to defraud the government while paying and receiving kickbacks during the pandemic.

3. Mark Schena, the president of Arrayit Corporation, was charged, for his connection with more than $70 million in false and fraudulent claims for allergy and COVID-19 tests. The tests were unreliable, according to prosecutors. Arrayit's vice president of marketing and the president of an Arizona marketing organization also were charged.

4. Peter Khaim and Arkadiy Khaimov, the owners of New York pharmacies and fake pharmacy wholesaling companies, were charged in a superseding indictment for allegedly participating in a money laundering scheme, submitting $45 million is false claims to Medicare and using COVID-19 "emergency override" billing codes to avoid pre-authorization requirements and limits for drug refills.

5. Dr. Alexander Baldonado of Queens, New York, allegedly ordered expensive and unnecessary genetic cancer testing for Medicare beneficiaries at a COVID-19 testing event, and billed Medicare for additional services he did not provide. Baldonado was charged with submitting approximately $17 million in fraudulent claims.

6. In an alleged $15 million scheme, Malena Lepetich, the owner of MedLogic Laboratories in Louisiana, offered to pay kickbacks for COVID-19 and respiratory pathogen testing referrals. Lepetich allegedly submitted more than $10 million in claims to Medicare, Medicaid, and Blue Cross Blue Shield of Louisiana for panels of expensive and medically unnecessary testing.

7. Florida residents Juan Nava Ruiz, Eric Frank and Christopher Licata were charged in a $9.3 million scheme involving kickbacks, Medicare beneficiary referrals to Boca Toxicology for unnecessary laboratory testing and claim submissions related to respiratory pathogen panel testing and genetic testing being improperly bundled with COVID-19 testing.

8. As a partner at a diagnostic testing laboratory in New York, Donald Clarkin was connected to a $5.4 million conspiracy to exploit the pandemic by offering kickbacks in exchange for respiratory pathogen panel tests to be improperly bundled with COVID-19 tests and billed to Medicare.

9. Hollywood Home Health Services' owner Petros Hannesyan allegedly misappropriated $229,454 from the CARES Act Provider Relief Fund and submitted false loan applications to the Economic Injury Disaster Loan Program, instead of using the funds for COVID-19 patient care and small business support.

The pandemic created a situation where the delivery of large sums of money was required quickly, in an untested manner, to provide adequate healthcare, said Mark Silberman, partner and vice chair of Benesch's national healthcare group.

"Anytime you have a significant outflow of government funds, you're also going to have the audit, investigation and enforcement period that follows," Silberman said.

The DOJ also levied charges against 42 doctors and nurses and around 100 other medical professionals in September for alleged healthcare fraud schemes that cost the government more than $1 billion in losses, $29 million of which came from pandemic-related fraud.

Clearer guidance regarding regulatory record keeping is needed to allow providers to do things the right way without falling subject to the investigative efforts, Silberman said

It is inevitable that in the coming months, more lawsuits and instances of healthcare fraud will come to light as investigations dig deeper into more institutions and smaller communities, said Robert Salcido, partner at Akin Gump Strauss Hauer & Feld.

Inline Play
