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DOJ Announces Coordinated Law Enforcement Action to Combat Health Care Fraud Related to COVID-19

Criminal Charges Against Telemedicine Company Executive, Physician, Marketers, and Medical Business Owners For COVID-19 Related Fraud Schemes with Losses Exceeding $143 Million

The Department of Justice today announced criminal charges against 14 defendants, including 11 newly-charged defendants and three who were charged in superseding indictments, in seven federal districts across the United States for their alleged participation in various health care fraud schemes that exploited the COVID-19 pandemic and resulted in over $143 million in false billings.

"The multiple health care fraud schemes charged today describe theft from American taxpayers through the exploitation of the national emergency," said Deputy Attorney General Lisa O. Monaco. "These medical professionals, corporate executives, and others allegedly took advantage of the COVID-19 pandemic to line their own pockets instead of providing needed health care services during this unprecedented time in our country. We are committed to protecting the American people and the critical health care benefits programs created to assist them during this national emergency, and we are determined to hold those who exploit such programs accountable to the fullest extent of the law."

Additionally, the Center for Program Integrity, Centers for Medicare & Medicaid Services (CPI/CMS) separately announced today that it took adverse administrative actions against over 50 medical providers for their involvement in health care fraud schemes relating to COVID-19 or abuse of CMS programs that were designed to encourage access to medical care during the pandemic.

"Medical providers have been the unsung heroes for the American public throughout the pandemic," said FBI Director Christopher Wray. "It's disheartening that some have abused their authorities and committed COVID-19 related fraud against trusting citizens. The FBI, along with our federal law enforcement and private sector partners, are committed to continuing to combat healthcare fraud and protect the American people."

The defendants in the cases announced today are alleged to have engaged in various health care fraud schemes designed to exploit the COVID-19 pandemic. For example, multiple defendants offered COVID-19 tests to Medicare beneficiaries at senior living facilities, drive-through COVID-19 testing sites, and medical offices to induce the beneficiaries to provide their personal identifying information and a saliva or blood sample. The defendants are alleged to have then misused the information and samples to submit claims to Medicare for unrelated, medically unnecessary, and far more expensive laboratory tests, including cancer genetic testing, allergy testing, and respiratory pathogen panel tests. In some cases, and as alleged, the COVID-19 test results were not provided to the beneficiaries in a timely fashion or were not reliable, risking the further spread of the disease, and the genetic, allergy, and respiratory pathogen testing was medically unnecessary, and, in many cases, the results were not provided to the patients or their actual primary care doctors. The proceeds of the fraudulent schemes were allegedly laundered through shell corporations and used to purchase exotic automobiles and luxury real estate.

"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," said Deputy Inspector General for Investigations Gary L. Cantrell of Health and Human Services – Office of Inspector General (HHS-OIG). "Our agency and its law enforcement partners are aggressively and effectively investigating these egregious crimes, which is made equally clear given the results of this takedown. We will continue to support the unprecedented COVID-19 public health effort by holding accountable people who use deceptive tactics to profit from the pandemic."

In another type of COVID-19 health care fraud scheme announced today, defendants are alleged to have exploited policies that were put in place by CMS to enable increased access to care during the COVID-19 pandemic. For example, pursuant to the COVID-19 emergency declaration, telehealth regulations and rules were broadened so that Medicare beneficiaries could receive a wider range of services from their doctors without having to travel to a medical facility. The cases announced today include first in the nation charges for allegedly exploiting these expanded policies by submitting false and fraudulent claims to Medicare for sham telemedicine encounters that did not occur. As part of these cases, medical professionals are alleged to have offered and paid bribes in exchange for the medical professionals' referral of medically unnecessary testing.

The law enforcement action today also includes the third set of criminal charges related to the misuse of Provider Relief Fund monies. The Provider Relief Fund is part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, a federal law enacted March 2020 designed to provide needed medical care to Americans suffering from COVID-19.

The Fraud Section is prosecuting the cases in the following districts: Western District of Arkansas, Northern District of California, Middle District of Louisiana, Central District of California, Southern District of Florida, District of New Jersey, and the Eastern District of New York.

Today's enforcement actions were led and coordinated by Assistant Chief Jacob Foster and Trial Attorneys Rebecca Yuan and Gary A. Winters of the National Rapid Response Strike Force of the Health Care Fraud Unit of the Criminal Division's Fraud Section, in conjunction with the Health Care Fraud Unit's Medicare Fraud Strike Forces (MFSF) in Miami, Los Angeles, the Gulf Coast, and Brooklyn, as well as the U.S. Attorneys' Offices for the Northern District of California, Western District of Arkansas, and Middle District of Louisiana.

The MFSF is a partnership among the Criminal Division, U.S. Attorneys' Offices, the FBI and HHS-OIG. In addition, U.S. Postal Inspection Service, Internal Revenue Service Criminal Investigation, Veterans Affairs Office of Inspector General, Department of Defense Office of Inspector General, Federal Deposit Insurance Corporation, Louisiana Medicaid Fraud Control Unit, and other federal and state law enforcement agencies participated in the law enforcement action.

The law enforcement action was brought in coordination with the Health Care Fraud Unit's COVID-19 Interagency Working Group, which is chaired by the National Rapid Response Strike Force and organizes efforts to address illegal activity involving health care programs during the pandemic.

The Fraud Section leads the Medicare Fraud Strike Force. Since its inception in March 2007, the Medicare Fraud Strike Force, which maintains 15 strike forces operating in 24 federal districts, has charged more than 4,200 defendants who have collectively billed the Medicare program for nearly $19 billion. In addition, the HHS Centers for Medicare and Medicaid Services, working in conjunction with the HHS-OIG, are taking steps to increase accountability and decrease the presence of fraudulent providers.

Case Summaries

Western District of Arkansas

- Billy Joe Taylor, 42, of Lavaca, Arkansas, was charged by criminal complaint with health care fraud in connection with an alleged scheme to defraud the United States of over $88 million, including over $42 million in false and fraudulent claims during the COVID-19 health emergency that were billed in combination with claims that were submitted for testing for COVID-19 and other respiratory illnesses. Taylor, the owner and operator of Vitas Laboratories LLC and Beach Tox LLC, two testing laboratories, allegedly used access to beneficiary and medical provider information from prior laboratory testing orders to submit fraudulent claims for urine drug tests and other laboratory tests, including respiratory pathogen panel and COVID-19 tests, that were not actually ordered or

performed. The complaint also alleges that hundreds of claims were submitted for beneficiaries after they had died or otherwise ceased providing samples. The case is being prosecuted by Senior Litigation Counsel James Hayes and Trial Attorney D. Keith Clouser of the National Rapid Response Strike Force, and Assistant U.S. Attorney Kenneth Elser of the U.S. Attorney's Office for the Western District of Arkansas.

Northern District of California

- Mark Schena, 58, of Los Altos, California, the president of Arrayit Corporation, is charged along with two others, the Arrayit Vice President of Marketing and the President of an Arizona marketing organization, in connection with the submission of over $70 million in false and fraudulent claims for allergy and COVID-19 testing. The superseding indictment against Schena includes new counts of health care fraud, a conspiracy to pay kickbacks, and payment of kickbacks in connection with false and fraudulent statements about the existence, regulatory status, and accuracy of an Arrayit COVID-19 test. The conspiracy allegedly sought to induce the ordering of the Arrayit COVID-19 test and to bundle, i.e., require combination with, the COVID-19 test and Arrayit's medically unnecessary allergy test. The COVID-19 test results were not provided in a timely fashion and were not reliable in detecting COVID-19. The cases are being prosecuted by Acting Principal Deputy Assistant Chief Justin Weitz of the Market Integrity and Major Fraud Unit of the Fraud Section, Assistant Chief Jacob Foster of the National Rapid Response Strike Force, and Assistant U.S. Attorney Wil Frentzen of the U.S. Attorney's Office for the Northern District of California.

Central District of California

- Petros Hannesyan, 36, of Burbank, California, was charged with the theft of government property and wire fraud in connection with $229,454 that he obtained from COVID-19 relief programs. Hannesyan, the owner of Hollywood Home Health Services, Inc., a home health agency located in Los Angeles, allegedly misappropriated funds from the CARES Act Provider Relief Fund and submitted false loan applications and a false loan agreement to the Economic Injury Disaster Loan Program, rather than use the funds for COVID-19 patient care and to support small businesses experiencing disruption due to the COVID-19 pandemic. The case is being prosecuted by Trial Attorney Alexis Gregorian of the Los Angeles Strike Force.

Southern District of Florida

- Michael Stein, 35, and Leonel Palatnik, 42, both of Palm Beach County, Florida, were charged in connection with an alleged $73 million conspiracy to defraud the United States and to pay and receive health care kickbacks during the COVID-19 pandemic. Stein, the owner and operator of purported consulting company 1523 Holdings, LLC, and Palatnik, an owner and operator of Panda Conservation Group, LLC, a Texas company that owned and operated testing laboratories in Dallas and Denton, Texas, allegedly exploited temporary waivers of telehealth restrictions enacted during the pandemic by offering telehealth providers access to Medicare beneficiaries for whom they could bill consultations. In exchange, these providers agreed to refer beneficiaries to Panda's laboratories for expensive and medically unnecessary cancer and cardiovascular genetic testing. The case is being prosecuted by Trial Attorney Ligia Markman of the National Rapid Response Strike Force.

- Juan Nava Ruiz, 44, and Eric Frank, 47, both of Coral Springs, Florida, were charged for an alleged $9.3 million health care kickback scheme, along with Christopher Licata, 44, of Boca Raton, Florida, who was previously charged in a separate Indictment. Licata, an owner of Boca Toxicology, LLC, a clinical laboratory based in Boca Raton, allegedly offered and paid kickbacks to patient brokers, including Ruiz and Frank, in exchange for referring Medicare beneficiaries to Boca Toxicology for various forms of genetic testing and other laboratory testing that they did not need, including the submission of $422,748 in claims related to medically unnecessary respiratory pathogen panel testing and genetic testing that was improperly bundled with COVID-19 testing. The cases are being prosecuted by Trial Attorney Jamie de Boer of the Miami Strike Force.

Middle District of Louisiana

- Malena Lepetich, 38, of Belle Chase, Louisiana, was charged for an alleged $15 million scheme to commit health care fraud, to defraud the United States, and to pay and receive health care kickbacks. Lepetich, the owner of MedLogic, LLC, a clinical laboratory based in Baton Rouge, Louisiana, allegedly solicited and received

kickbacks in exchange for referrals of urine specimens for medically unnecessary testing. Lepetich also allegedly offered to pay kickbacks for referrals of specimens for COVID-19 and respiratory pathogen testing. Finally, Lepetich allegedly caused the submission of over $10 million in claims to Medicare, Medicaid, and Blue Cross Blue Shield of Louisiana for panels of expensive respiratory testing that was medically unnecessary. The case is being prosecuted by Trial Attorney Justin M. Woodard of the Gulf Coast Strike Force and Assistant U.S. Attorney Kristen Craig of the U.S. Attorney's Office for the Middle District of Louisiana.

District of New Jersey

- Alexander Baldonado, 65, of Queens, New York, was charged with six counts of health care fraud. Baldonado, a medical doctor, allegedly participated in an event that advertised COVID-19 testing. In addition to authorizing the COVID-19 tests, Baldonado allegedly ordered expensive and medically unnecessary cancer genetic testing for Medicare beneficiaries who attended the event. Baldonado also allegedly billed Medicare for services, including lengthy office visits, that he never provided to these beneficiaries. Approximately $2 million in claims were submitted as a result of Baldonado's COVID-19 health care fraud scheme, and approximately $17 million in claims were submitted as a result of Baldonado's broader health care fraud scheme. The case is being prosecuted by Trial Attorney Rebecca Yuan of the National Rapid Response Strike Force.

- Donald Clarkin, 65, of Staten Island, New York, was charged in connection with a $5.4 million conspiracy to defraud the United States and pay and receive health care kickbacks. Clarkin, a partner at a diagnostic testing laboratory, allegedly exploited the pandemic by offering kickbacks in exchange for respiratory pathogen panel tests that would be improperly bundled with COVID-19 tests and billed to Medicare. Clarkin also allegedly paid and received kickbacks and bribes in exchange for arranging for the ordering of medically unnecessary genetic tests that were ineligible for Medicare reimbursement. The case is being prosecuted by Trial Attorney Rebecca Yuan of the National Rapid Response Strike Force.

Eastern District of New York

- Peter Khaim, 41, and Arkadiy Khaimov, 38, both of Forest Hills, New York, who owned and controlled several New York pharmacies and sham pharmacy wholesaling companies, were charged in a superseding indictment for their participation in an alleged $45 million health care fraud, wire fraud, and money laundering scheme. The defendants and their co-conspirators allegedly obtained billing privileges for multiple pharmacies by using nominees to serve as the purported owners and supervising pharmacists. The defendants then allegedly submitted false and fraudulent claims to Medicare, including by using COVID-19 "emergency override" billing codes to circumvent otherwise applicable pre-authorization requirements and limits on the frequency of refills for expensive drugs (primarily, the cancer treatment gels Targretin and Panretin). The defendants allegedly used an elaborate network of international money laundering operations to conceal and disguise the proceeds of the scheme. The case is being prosecuted by Trial Attorney Andrew Estes of the Brooklyn Strike Force.

The Department of Justice needs the public's assistance in remaining vigilant and reporting suspected fraudulent activity. To report suspected fraud, contact the National Center for Disaster Fraud (NCDF) at (866) 720-5721 or file an online complaint at: https://www.justice.gov/disaster-fraud/webform/ncdf-disaster-complaint-form. Complaints filed will be reviewed at the NCDF and referred to federal, state, local, or international law enforcement or regulatory agencies for investigation.

To learn more about the department's COVID response, visit: https://www.justice.gov/coronavirus. For further information on the Criminal Division's enforcement efforts on PPP fraud, including court documents from significant cases, visit the following website: https://www.justice.gov/criminal-fraud/ppp-fraud.

An indictment, complaint, or information is merely an allegation, and all defendants are presumed innocent until proven guilty beyond a reasonable doubt in a court of law.

Topic(s):
Coronavirus
Disaster Fraud

Health Care Fraud

Component(s):
Criminal Division
Criminal - Criminal Fraud Section
Office of the Deputy Attorney General
USAO - Arkansas, Western
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