Crackdown on COVID-19 Testing Fraud Continues

COVID-19-related schemes dominated recent enforcement efforts, which include a national healthcare fraud enforcement action

By Karen Lovitch and Jane Haviland

CityMD Pays More than $12M to Settle False Claims Allegations Related to the COVID-19 Uninsured Program

Case: On June 7, CityMD and related parties operating more than 100 urgent care practices in New Jersey and New York agreed to pay more than $12 million to resolve False Claims Act (FCA)-related allegations. The DOJ claims the defendants violated the FCA by submitting or causing the submission of false claims for COVID-19 testing to the Health Resources and Services Administration (HRSA) program covering testing for uninsured patients (Uninsured Program, or UIP). Allegedly, CityMD (1) knew their patients were insured at the time of testing, (2) did not adequately confirm whether patients had health insurance coverage before submitting claims (including for patients whom CityMD had health insurance cards on file), and (3) caused outside laboratories to submit false claims for insured patients "by issuing requisition forms erroneously indicating that patients were uninsured."[1]

The settlement resolves a *qui tam* lawsuit brought by a patient of CityMD who received over $2 million under the settlement, including attorneys' fees. CityMD received credit[2] in the settlement under U.S. Department of Justice (DOJ) guidelines for voluntary disclosure, cooperation, and remediation. Specifically, CityMD voluntarily contracted with a third party to aid the government with the damages calculation. CityMD did not admit liability as a condition of settlement; in fact, CityMD denied the alleged conduct.[3]

Significance: CityMD appears to have benefitted financially from cooperating with the government's investigation, as the restitution amount ($8,996,487) compared to the total settlement amount ($12,037,109) suggests application of a roughly 1.3x damages multiplier instead of double damages, which the government typically seeks in FCA settlements.[3]

The settlement represents another success for the COVID-19 Fraud Enforcement Task Force, established by the Attorney General in May 2021. COVID-19 fraud prosecution has historically focused primarily on criminal actions. This focus is likely due to the complexity and resource-intensive nature of FCA prosecutions and the desire to prioritize prosecution of overt, criminal, large-dollar fraud. FCA cases based on COVID-19 fraud are likely to increase in the coming years as the government continues to leverage data analytics, artificial intelligence, and its traditional investigative tools.

The Government Intervenes in FCA Case Alleging Fraudulent Billing for COVID-19 Testing

Case: On June 13, the United States, through the U.S. Attorney's Office for the Southern District of New York (USAO), filed a lawsuit against LabQ Clinical Diagnostics, LLC, related entities, and their CEO for alleged FCA and common law violations related to claims submitted to the UIP for COVID-19 testing.[4] The lawsuit alleges that LabQ and the other defendants engaged in the following conduct:[5]

1. Knowingly submitting or causing the submission of claims to the UIP for COVID-19 testing when reimbursement from another source was available or when the patient had insurance on the date of service.

2. Double-billing the UIP for testing billed to other entities.

3. Informing patients that LabQ did not need insurance information.

4. Seeking reimbursement from HRSA for testing provided to patients with insurance when LabQ thought insurers might deny LabQ's claims.

5. Submitting claims to the UIP when LabQ's own records showed a patient had insurance.

6. Automatically "flipping" claims paid by insurers to the UIP for additional payment.

7. Failing to train employees to adequately collect insurance information and taking no corrective action even though LabQ's own data reflected that a "virtually impossible" percentage of their patients were supposedly uninsured.

LabQ received approximately $130 million from the UIP. The CEO allegedly transferred over $100 million from the involved corporate parties to himself and a limited liability company (LLC) he owned and controlled, and then used the funds to purchase dozens of houses in New Jersey.

The government intervened on behalf of two *qui tam* LLC complainants composed in part of former LabQ employees, seeking treble damages under the FCA and common law damages under mistake of fact and unjust enrichment theories. The complaint alleged that LabQ "failed to have anything close to an adequate compliance program concerning their billing of federal health care programs" during the relevant time period.[5]

Significance: This case, announced less than a week after the CityMD case summarized above, is in stark contrast to that earlier case, which involved a defendant who cooperated with the government and received credit for doing so. Here, the USAO intervened in the *qui tam* case filed by the relators and likely was motivated at least in part by the CEO's alleged transfer of millions of dollars of funds to his own accounts and by LabQ's seemingly systemic lack of regard for HRSA's program rules.

National Healthcare Fraud Enforcement Action Targets Telemedicine and Laboratory Fraud

Case: On June 27, 2024, the DOJ announced the results of a national healthcare fraud enforcement action led by the Health Care Fraud Strike Force, resulting in charges against 193 defendants—more than a third of whom were licensed medical professionals—in 32 federal districts and 11 states. The defendants allegedly participated in schemes involving approximately $2.75 billion in intended losses and $1.6 billion in actual losses. The government seized over $231 million in cash, luxury vehicles, gold, and other assets in connection with the enforcement action.[6]

The action involved various alleged fraud schemes, including telemedicine and laboratory fraud totaling more than $1.1 billion. Thirty-six defendants allegedly participated in similar schemes whereby clinical laboratories submitted false or fraudulent claims to federal programs. These alleged schemes included COVID-19 and genetic testing tainted by kickbacks paid to laboratory owners, telemedicine providers, marketers, and others. For example, the charging documents made the following allegations:[7]

- **Spectrum Lab Corp.** billed Medicare for over-the-counter COVID-19 test kits that were neither requested nor delivered, or purportedly delivered to deceased beneficiaries, resulting in the submission of more than $15 million in false and fraudulent claims to Medicare and payments by Medicare of approximately $7.1 million. Spectrum submitted more than 75,000 unique claims to Medicare for reimbursement over a four-day period in November 2023. It had previously submitted relatively few claims.[8]

- **Choice Medical Services** and **Laboratorio Clinico de San Juan, Inc.,** billed federal healthcare programs and received reimbursement for services never provided.

- **ASAP Lab, LLC** submitted claims to Medicare for COVID-19 and respiratory panel testing using requisition forms with forged or unauthorized medical practitioner signatures procured by a sales representative in exchange for kickbacks.[9]

- **Alliance Laboratories** received over $5 million from Medicare in connection with a scheme whereby conspirators gained access to Medicare beneficiary information in connection with COVID-19 testing. They used that information to bill Medicare for genetic tests that providers did not order and that beneficiaries did not receive.[10]

- The owner of **Axis Professional Labs, LLC** and **Kingdom Health Laboratory, LLC** offered and paid kickbacks to marketers in exchange for referring Medicare beneficiaries' DNA samples, personally identifiable information (including Medicare numbers), and signed doctors' orders authorizing medically unnecessary cardio genetic testing to Axis and Kingdom. The owner of Axis and Kingdom attempted to disguise the kickback arrangement with marketers through sham contracts purportedly paying hourly rates, when the marketers in fact received payments on a per-sample basis.[11]

- **Innovative Genomics** billed Medicare for COVID-19 and genetic test orders generated in exchange for kickbacks that Innovative Genomics' owners paid to physicians and patient recruiters. The owner of **Bio Choice** and **Bios Scientific** used a sham "flat fee" contractual arrangement to disguise payments to a marketer for the referral of Medicare beneficiary DNA samples and signed doctors' orders for genetic testing that the labs used to bill Medicare. Innovative Genomics, Bio Choice, and Bios Scientific also violated the Shell Lab Rule, which prohibits a referring laboratory from receiving reimbursement from Medicare if it refers more than 30 percent of its testing.[12]

Significance: The Health Care Fraud Unit within the DOJ's Criminal Division, Fraud Section, led the enforcement action. The Health Care Fraud Unit has a dedicated data analytics team that monitors billing trends and identifies aberrant providers which has led to, in the words of Principal Deputy Assistant Attorney General Nicole Argentieri, "outsized returns."[13] The facts comprising the underlying charges in the action seem to indicate that the government is looking closely at COVID-19 testing paired with genetic testing in addition to monitoring data outliers demonstrating spikes in claims for reimbursement.

In remarks about the action, Argentieri referred to the DOJ's whistleblower rewards program announced earlier in 2024, indicating that if defendants call the DOJ before the agency calls on them, and assist the DOJ with "prosecuting more culpable individuals," relators may "earn a non-prosecution agreement."[13] The whistleblower rewards program may further incentivize relators to report suspected fraud on COVID-19 and other government programs before data analytics lead the government to come knocking.

REFERENCES:

1. https://www.justice.gov/opa/pr/citymd-agrees-pay-over-12-million-alleged-false-claims-covid-19-uninsured-program
2. This agreement credits CityMD under the Department of Justice's Guidelines for Taking Voluntary Disclosure, Cooperation and Remediation into Account in False Claims Act Matters, Justice Manual § 4-4.112
3. https://www.justice.gov/opa/media/1355186/dl?inline
4. https://www.justice.gov/usao-sdny/pr/us-attorney-files-civil-fraud-suit-against-labq-and-its-ceo-fraudulently-billing-covid
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