

PANDEMIC-RELATED SCHEME



Scammers leveraged pandemic-related circumstances to prey on Medicare beneficiaries. Then they used the beneficiaries' Medicare information to fraudulently bill for medically unnecessary testing and medical equipment.*

* This graphic represents tactics used in some, but not all, schemes investigated as part of the 2021 National Health Care Fraud Enforcement Action.

The Alleged SCHEME



Marketers leveraged pandemic-related circumstances—making cold calls and using ads to offer beneficiaries access to a number of services. While collecting beneficiaries' information, marketers suggested additional, unnecessary services possibly unrelated to the service offered.

 Marketers collected beneficiaries' genetic samples and Medicare information intending for them to be used in **fraudulent billing of Medicare**.



Conspiring medical providers authorized referrals for the unnecessary services in exchange for kickback payments by marketers, labs, and durable medical equipment (DME) companies. Referrals are required for Medicare payment of these services.

 If beneficiaries had consultations with these providers, appointments were brief and **did not sufficiently determine need for services**.

Fraudulent labs purchased from marketers DNA samples that beneficiaries submitted by mail or in person. Labs used beneficiaries' information to bill Medicare for unrelated testing (e.g., genetic testing). **Fraudulent DME companies** purchased from marketers beneficiaries' Medicare information. Companies sent beneficiaries medical equipment (e.g., orthotic braces) and billed Medicare.

 These tests and equipment were **medically unnecessary** and more expensive.

Labs and DME companies received reimbursement for the additional, medically unnecessary testing and equipment.

 Medicare paid for **illegitimate** and **inappropriate** services.
 Beneficiaries were potentially responsible for any costs of tests denied by Medicare.

HHS-OIG Investigates: Pandemic-Related Scheme

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