Department of Justice

U.S. Attorney's Office

Western District of Tennessee

FOR IMMEDIATE RELEASE Wednesday, April 20, 2022

Justice Department Announces Nationwide Coordinated Law Enforcement Action to Combat Health Care Related COVID-19 Fraud

Criminal Charges Brought Against Owners and Executives of Medical Businesses, Physicians, Marketers, and Manufactures of Fake COVID-19 Vaccination Record Cards with Losses Exceeding $149 Million

Memphis, TN - The Department of Justice today announced criminal charges against 21 defendants in nine federal districts across the United States for their alleged participation in various health care related fraud schemes that exploited the COVID-19 pandemic. These cases allegedly resulted in over $149 million in COVID-19-related false billings to federal programs and theft from federally-funded pandemic assistance programs. In connection with the enforcement action, the department seized over $8 million in cash and other fraud proceeds.

"The Department of Justice's Health Care Fraud Unit and our partners are dedicated to rooting out schemes that have exploited the pandemic," said Assistant Attorney General Kenneth A. Polite, Jr. of the Justice Department's Criminal Division. "Today's enforcement action reinforces our commitment to using all available tools to hold accountable medical professionals, corporate executives, and others who have placed greed above care during an unprecedented public health emergency."

"This COVID-19 health care fraud enforcement action involves extraordinary efforts to prosecute some of the largest and most wide-ranging pandemic frauds detected to date," said Director for COVID-19 Fraud Enforcement Kevin Chambers. "The scale and complexity of the schemes prosecuted today illustrates the success of our unprecedented interagency effort to quickly investigate and prosecute those who abuse our critical health care programs."

This announcement builds on the success of the May 2021 COVID-19 Enforcement Action and involves the prosecution of various COVID-19 health care fraud schemes. For example, several cases announced today involve defendants who allegedly offered COVID-19 testing to induce patients to provide their personal identifying information and a saliva or blood sample. The defendants are alleged to have then used the information and samples to submit false and fraudulent claims to Medicare for unrelated, medically unnecessary, and far more expensive tests or services. In one such scheme in the Central District of California, two owners of a clinical laboratory were charged with a health care fraud, kickback, and money laundering scheme that involved the fraudulent billing of over $214 million for laboratory tests, over $125 million of which allegedly involved fraudulent claims during the pandemic for COVID-19 and respiratory pathogen tests. In two separate cases in the District of Maryland and the Eastern District of New York, owners of medical clinics allegedly obtained confidential information from patients seeking COVID-19 testing at drive-thru testing sites and then submitted fraudulent claims for lengthy office visits with the patients that did not, in fact, occur. The proceeds of these fraudulent schemes were allegedly laundered through shell

corporations in the United States, transferred to foreign countries, and used to purchase real estate and luxury items.

“Throughout the pandemic, we have seen trusted medical professionals orchestrate and carry out egregious crimes against their patients all for financial gain,” said Assistant Director Luis Quesada of the FBI’s Criminal Investigative Division. “These health care fraud abuses erode the integrity and trust patients have with those in the health care industry, particularly during a vulnerable and worrisome time for many individuals. The actions of these criminals are unacceptable, and the FBI, working in coordination with our law enforcement partners, will continue to investigate and pursue those who exploit the integrity of the health care industry for profit.”

In the Western District of Tennessee, Raymond Earl Vallier, 52, of Collierville, Tennessee was indicted with theft of government property and aggravated identity theft in connection with a scheme to unlawfully convert CARES Act Provider Relief Fund monies. Vallier was the former owner and operator of North Delta Hospice and Palliative Services LLC, a hospice care center, which, on April 10, 2020, received $107,568.03 from the Provider Relief Fund. North Delta Hospice had ceased seeing patients and billing Medicare and Medicaid by the end of September 2019. According to the indictment, rather than returning the funds deposited, as North Delta Hospice did not qualify for the Provider Relief Fund Payment, the defendant used the name of the deceased owner of North Delta Hospice to falsely attest to the terms and conditions of the Provider Relief Fund — claiming that the funds would be used for expenses related to the treatment of COVID-19 patients — and wrote a check to himself and made a payment on one of his other company’s credit card accounts with the funds. This case is being prosecuted by Trial Attorney Sara E. Porter of the Gulf Coast Strike Force and Assistant U.S. Attorney Tony Arvin of the U.S. Attorney’s Office for the Western District of Tennessee.

In another type of COVID-19 health care fraud scheme announced today, defendants allegedly exploited policies that the Centers for Medicare and Medicaid Services (CMS) put in place to enable increased access to care during the COVID-19 pandemic. For example, in the Southern District of Florida, one medical professional was charged with a health care fraud, wire fraud, and kickback scheme that allegedly involved billing for sham telemedicine encounters that did not occur and agreeing to order unnecessary genetic testing in exchange for access to telehealth patients. Late last year, one defendant previously was sentenced to 82 months in prison in connection with this scheme.

“The attempt to profit from the COVID-19 pandemic by targeting beneficiaries and stealing from federal health care programs is unconscionable,” said Inspector General Christi A. Grimm of the Department of Health and Human Services (HHS). “HHS-OIG is proud to work alongside our law enforcement partners at the federal and state levels to ensure that bad actors who perpetrate egregious and harmful crimes are held accountable.”

Today’s announcement includes charges against two additional defendants for schemes targeting the Provider Relief Fund (PRF). The PRF is part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, a federal law enacted in March 2020 that provided financial assistance to medical providers to provide needed medical care to Americans suffering from COVID-19. In total, 10 defendants have been charged with crimes related to misappropriating PRF monies intended for frontline medical providers and three have pleaded guilty.

Today’s announcement also includes charges against manufacturers and distributors of fake COVID-19 vaccination record cards who, according to the allegations, intentionally sought to obstruct the HHS and Centers for Disease Control and Prevention in their efforts to administer the nationwide vaccination program and provide Americans with accurate proof of vaccination. For example, in the Northern District of California, three additional defendants were charged in a scheme to sell homeoprophylaxis immunizations for COVID-19 and falsify COVID-19 vaccination record cards to

make it appear that customers received government-authorized vaccines. One defendant allegedly misused her position as the Director of Pharmacy at a northern California hospital to obtain real lot numbers for the Moderna vaccine that were then used to falsify COVID-19 vaccination record cards. Another defendant pleaded guilty in April 2022. In a separate case in the Western District of Washington, one manufacturer was charged in the multistate distribution of fake COVID-19 vaccination record cards after allegedly telling an undercover federal agent that "until I get caught and go to jail, [expletive] it I'm taking the money, ha! I don't care."

Additionally, the Center for Program Integrity, Centers for Medicare & Medicaid Services (CPI/CMS) separately announced today that it has taken an additional 28 administrative actions against providers for their alleged involvement in fraud, waste, and abuse schemes related to the delivery of care for COVID-19, as well as schemes that capitalize upon the public health emergency.

"We are committed to working closely with our law enforcement partners to combat fraud, waste and abuse in our federal health care programs," said CMS Administrator Chiquita Brooks-LaSure. "The administrative actions CMS has taken protect the Medicare Trust Funds while also safeguarding people enrolled in Medicare."

Today's enforcement actions were led and coordinated by Assistant Chief Jacob Foster and Trial Attorney D. Keith Clouser of the National Rapid Response Strike Force, and Assistant Chief Justin Woodard of the Health Care Fraud Unit's Gulf Coast Strike Force in the Criminal Division's Fraud Section. The Fraud Section's National Rapid Response Strike Force and the Health Care Fraud Unit's Strike Forces (SF) in Brooklyn, the Gulf Coast, Miami, Los Angeles, and Newark, as well as the U.S. Attorneys' Offices for the District of Maryland, District of New Jersey, District of Utah, Northern District of California, and Western District of Tennessee are prosecuting these cases. Descriptions of each case involved in today's enforcement action are available on the department's website at: https://www.justice.gov/criminal-fraud/health-care-fraud-unit/case-summaries.

In addition to the FBI, HHS-OIG, and CPI/CMS, the U.S. Postal Inspection Service; Department of Defense Office of Inspector General; Department of the Interior Office of the Inspector General; Department of Labor Office of the Inspector General; Food and Drug Administration Office of the Inspector General; Homeland Security Investigations; U.S. Department of Veterans Affairs Office of the Inspector General; and other federal and local law enforcement agencies participated in the law enforcement action.

The Fraud Section leads the Health Care Fraud Strike Force. Since its inception in March 2007, the Health Care 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 CMS, working in conjunction with the HHS-OIG, are taking steps to increase accountability and decrease the presence of fraudulent providers.

On May 17, 2021, the Attorney General established the COVID-19 Fraud Enforcement Task Force to marshal the resources of the Department of Justice in partnership with agencies across government to enhance efforts to combat and prevent pandemic-related fraud. The Task Force bolsters efforts to investigate and prosecute the most culpable domestic and international criminal actors and assists agencies tasked with administering relief programs to prevent fraud by, among other methods, augmenting and incorporating existing coordination mechanisms, identifying resources and techniques to uncover fraudulent actors and their schemes, and sharing and harnessing information and insights gained from prior enforcement efforts. For more information on the department's response to the pandemic, please visit https://www.justice.gov/coronavirus.

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.

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.

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Updated April 20, 2022