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Client Alert: Health Care Schemes, Errors, and Side Hustles, Part 2

In this edition, we explore a Stark law allegation, opioids, and telehealth. It is always advisable to know what is going on in the health care industry!

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Keep in mind that one person's scheme is another person's side hustle in today's world. The following is according to the United States Attorney's Office and represents their statement of the issue or perspective. The other party to the matter may disagree. With those factors in mind, we present some of the notable activities of late:

Hospital Agrees to Pay \$1.7M to Resolve Alleged Stark Law Violations

A hospital company has agreed to pay the United States \$1.7 million to resolve allegations relating to improper financial relationships between the hospital and two referring physicians. The company operates a hospital located in the midwest. The hospital disclosed the arrangements at issue to the government following an independent investigation. The Physician Self-Referral Law, commonly known as the Stark Law, prohibits hospitals from billing for certain services referred by physicians with whom the hospital has a financial relationship, unless that relationship satisfies one of the law's statutory or regulatory exceptions. The settlement resolves allegations that from 2014 through 2020 the hospital made improper financial contributions to two referring physicians in the form of rental arrangements for office space. The United States alleged that these arrangements violated the Stark Law because the rental arrangements exceeded fair market value. In connection with the settlement, the United States acknowledged that the hospital took significant steps entitling it to credit for cooperating with the government. The U.S. Attorney's Office stated that the claims resolved by the United States in the settlement are allegations only and there has been no determination of liability.

Texas Doctor Charged with Illegally Distributing Millions of Opioid Pills

The following is according to the United States Attorney's Office:

An indictment was unsealed in the Southern District of Texas charging a Texas doctor with operating a cash-only clinic in Houston that he used to sell prescriptions for controlled substances. According to court documents, this medical doctor licensed to practice in Texas conspired with others to illegally prescribe oxycodone, hydrocodone, and carisoprodol—all controlled substances with substantial street value that were

in high demand on Houston's black market. Operating from his cash-only Houston clinic, the doctor allegedly sold prescriptions to "crew leaders" who recruited others to pose as patients, filled the doctors' prescriptions at complicit pharmacies, and resold the drugs on the black market. As alleged, the doctor often did not see or examine his purported patients before prescribing them with opioids and other controlled substances. In just over four years, the physician allegedly prescribed approximately 2.9 million pills of hydrocodone, 1.3 million pills of oxycodone, and 1.1 million pills of carisoprodol. In less than three years of the conspiracy, more than \$2 million in cash was deposited into bank accounts controlled by the doctor. The doctor is charged with one count of conspiracy to distribute and dispense controlled substances, one count of distributing and dispensing controlled substances, and one count of maintaining a drug involved premises. If convicted, he faces a maximum penalty of 20 years in prison on each count. As noted by the U.S. Attorney's Office, an indictment is merely an allegation. All defendants are presumed innocent until proven guilty beyond a reasonable doubt in a court of law.

Telemedicine Company Owner Pleads Guilty to \$46M Medicare Fraud Scheme

The owner of a telemedicine company pleaded guilty to organizing and leading a \$46.2 million Medicare fraud conspiracy that spanned more than six years. According to court documents, a Fort Lauderdale, Florida man admitted that he owned and operated a telemedicine company. The man and his co-conspirators targeted Medicare patients through aggressive telemarketing campaigns, inducing them to accept orthotic braces and genetic tests that they did not need. He paid doctors to approve orders for these braces and genetic tests. These doctors did not follow Medicare's rules for telemedicine visits, did not have real medical relationships with the Medicare patients, and often signed orders for orthotic braces and genetic tests without any meaningful interaction with the Medicare patients. He then sold the signed doctors' orders to durable medical equipment (DME) supply companies, laboratories, and marketers who were part of the scheme. The man also owned and operated multiple DME supply companies based in Florida that he used to bill Medicare millions of dollars for orthotic braces that Medicare patients did not want or need. In total, at least \$46.2 million in false and fraudulent claims were submitted to Medicare as part of the scheme. Medicare paid \$17.9 million based on these claims, and he personally received more than \$10.4 million from the fraud scheme. The man pleaded guilty to conspiracy to commit health care fraud and wire fraud and agreed to pay \$17.9 million in restitution. Sentencing will be scheduled at a later date. He faces a maximum sentence of 20 years in prison. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

In the first case referenced, we see confirmation that physician-hospital rental arrangements continue to present compliance risks. Fortunately, the hospital proactively investigated, corrected, and self-reported the issue. The government's response reflects the importance of these actions, specifically recognizing the organization's remediation efforts and cooperation as mitigating factors.

In the second matter, a physician is alleged to have participated in a pill mill operation and now faces the possibility of significant criminal penalties, including imprisonment, if convicted.

In the third case, authorities allege the existence of a referral network involving DME suppliers, physicians, telehealth providers, and others who generated medically unnecessary or otherwise improper claims for reimbursement.

Together, these cases serve as important reminders that fair market value remains a critical compliance consideration, documentation can either protect or undermine an organization, and health care providers must remain vigilant regarding their referral relationships. Participation in—or even proximity to—an improper referral network can expose an organization to substantial legal, financial, and reputational risks, as well as significant costs associated with investigations and defense.

For more information, please contact Grant Dearborn, Ginny Dailey, or another member of Shumaker's Health Law Team.