Southern California Doctor Found Guilty in $12 Million Medicare Fraud and Device Adulteration Scheme

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A federal jury found a southern California doctor guilty yesterday for his role in a $12 million scheme to provide medically unnecessary procedures to Medicare beneficiaries, upcode claims submitted to Medicare, and re-package single-use catheters for reuse on patients.

Assistant Attorney General Brian A. Benczkowski of the Justice Department's Criminal Division, U.S. Attorney Nicola T. Hanna of the Central District of California, Assistant Director in Charge Paul Delacourt of the FBI's Los Angeles Field Office, Special Agent in Charge Timothy DeFrancesca of the U.S. Department of Health and Human Services Office of the Inspector General's (HHS-OIG) Los Angeles Regional Office and Special Agent in Charge

Lisa Malinowski of the U.S. Food and Drug Administration Office of Criminal Investigations' (FDA-OCI) Los Angeles Field Office made the announcement.

After a six-day trial, Donald Woo Lee, 54, of Temecula, California, was found guilty of seven counts of health care fraud and one count of adulteration of a medical device. Sentencing has been scheduled for March 19, 2020, before U.S. District Judge George Wu of the Central District of California, who presided over the trial.

According to evidence presented at trial, from 2012 to 2015, Lee engaged in a scheme in which he recruited Medicare beneficiaries to his clinics, falsely diagnosed the beneficiaries with venous insufficiency and provided the beneficiaries with medically unnecessary vein ablation procedures. The evidence further established that Lee billed these

unnecessary procedures to Medicare using an inappropriate code in order to obtain a higher reimbursement, a practice known as “upcoding.” In addition, the evidence showed that Lee repackaged used, contaminated catheters for re-use on patients. These catheters had been cleared by the FDA for marketing as single-use only. Lee submitted claims of approximately $12 million to Medicare for the vein ablation procedures he performed, and received $4.5 million as a result, the evidence showed.

This case was investigated by the FBI, HHS-OIG and FDA-OCI, and was brought as part of the Medicare Fraud Strike Force, under the supervision of the Criminal Division’s Fraud Section and the U.S. Attorney’s Office for the Central District of California. Trial Attorneys Alexis Gregorian and Emily Culbertson of the Fraud Section are prosecuting the case.

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 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 & Medicaid Services, working in conjunction with the HHS-OIG, are taking steps to increase accountability and decrease the presence of fraudulent providers.