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Genetic Testing Fraud Scheme Submitted More Than $522 Million in False Claims

Genetic testing fraud schemes steal money from federal healthcare programs, diverting resources away from beneficiaries who rely on them. These schemes often involve falsifying medical necessity documentation, obtaining fraudulent test orders, billing for medically unnecessary genetic tests, and paying illegal kickbacks.

For example, in May 2026, the Department of Justice announced the sentencing of two operators of multiple clinical laboratories who orchestrated a nationwide genetic testing fraud scheme and submitted more than $522 million in false claims to Medicare, Medicaid, and private health insurers. According to court documents, the defendants paid illegal kickbacks and bribes to marketers and medical providers to obtain DNA samples and fraudulent laboratory requisition forms for beneficiaries who had not been evaluated or treated by the ordering providers. Beneficiaries were recruited through telemarketing, door-to-door solicitation, health fairs, and other outreach efforts.

To support the fraudulent claims, the defendants falsified laboratory requisition forms, letters of medical necessity, and other medical records to make medically unnecessary genetic tests appear legitimate. The laboratories received approximately $84 million in payments before the scheme was uncovered. To conceal the fraud, the defendants used sham contracts and invoices to disguise illegal kickback payments as legitimate marketing expenses.

Genetic testing fraud schemes can drain taxpayer resources, threaten the integrity of federal healthcare programs, and divert funds intended to support beneficiaries. CMS remains committed to identifying and stopping improper payments before they occur.

CMS is Strengthening Protections Against Genetic Testing Fraud

CMS and its Center for Program Integrity use advanced analytics, payment controls, and investigative tools to identify suspect laboratory billing activity, detect fraudulent genetic testing schemes, and prevent improper payments.

Recent actions include:

- **Targeted payment denials:** CMS has denied more than **$73.2 million** in Medicare payments associated with improper laboratory billing activity so far in 2026.
- **Payment suspensions:** CMS has suspended approximately **$38.8 million** in Medicare payments linked to laboratories identified through ongoing program integrity reviews and investigations by the Fraud Defense Operations Center so far in 2026.
- **Enhanced oversight:** CMS continues to monitor billing patterns, investigate emerging fraud trends, and coordinate with law enforcement partners to protect beneficiaries and taxpayer dollars.

CMS has zero tolerance for fraud, waste, and abuse, and will continue strengthening safeguards to protect federal healthcare programs from bad actors.

Sources

U.S. Department of Justice, “Two Sentenced to Prison for $522M Genetic Testing Fraud and Illegal Kickback Scheme Targeting Medicare and Medicaid,” May 4, 2026.

https://www.justice.gov/opa/pr/two-sentenced-prison-522m-genetic-testing-fraud-and-illegal-kickback-scheme-targeting