
"Marketing the Spread": The Skin Substitute Fraud Where Every Graft Was Real

Most people picture health care fraud as phantom patients or services never rendered. But in many skin substitute cases, the patients were real, the wounds were real, and the grafts were actually applied. The fraud was in the price.

This is the second post in our series on False Claims Act cases involving skin substitutes and wound care. It looks at the sales practice at the center of many of them, which the government calls "marketing the spread," and at the people who are best positioned to expose it.

What the "spread" is

The spread is the gap between what a provider pays for a product and what the provider collects from Medicare for using it. HHS-OIG defined the term more than two decades ago, in its compliance guidance for drug manufacturers:

The "spread" is the difference between the amount a customer pays for a product and the amount the customer receives upon resale of the product to the patient or other payer. In many situations ... manufacturers control not only the amount at which they sell a product to their customers, but also the amount those customers who ... bill the federal health care programs will be reimbursed. To the extent that a manufacturer controls the "spread," it controls its customer's profits. See *OIG Compliance Program Guidance for Pharmaceutical Manufacturers*, 68 Fed. Reg. 23731, 23736 (May 5, 2003).

Skin substitutes gave manufacturers unusual control over both ends of that equation. Until January 2026, Medicare paid for most of these products at the manufacturer's self-reported average sales price plus six percent, per square centimeter. Products too new to have an ASP were paid from the manufacturer's own invoice or list price. A manufacturer that reported a high price to Medicare, then quietly sold the same graft to practitioners for far less, had manufactured a spread. And once a manufacturer controls the spread, OIG's warning applies with full force: it controls the practitioner's profit, and the practitioner's profit starts to control the practitioner's clinical decisions.

How the pitch works

The sales conversation rarely begins with healing rates. It begins with a number: what the doctor, nurse practitioner, or podiatrist will clear on every application. (Anyone who can bill Medicare for applying a graft can get the same pitch, so this post uses

"practitioner" to cover all of them.) A typical invoice-pricing version of the scheme runs like this.

1. A manufacturer or distributor approaches a wound care practice with a promise that the practice will make money on every graft it applies.
2. The parties reach an understanding, sometimes a signed agreement and sometimes nothing more than a conversation with a sales representative, under which the practice receives a discount, often framed as a rebate or credit, on each purchase. The rebate may be a fixed percentage or tied to volume.
3. The invoice that accompanies each shipment shows the full, undiscounted price. The rebate appears nowhere on it.
4. The practice applies the graft to a Medicare patient and bills Medicare based on the full invoice price, or at the ASP-based rate that the manufacturer's inflated reported prices produced.
5. The manufacturer waits to collect. In practice, the practice does not pay the manufacturer anything until after Medicare has paid the practice, even if whatever written terms exist say payment is due within thirty or sixty days.
6. The practice keeps the spread, and the manufacturer keeps a customer with every incentive to apply more grafts, larger grafts, and more expensive grafts.

Where there is a written agreement, it often looks defensible on its face. Where there is none, the understanding lives in sales calls and text messages. Either way, the fraud lives in the gap between what was said and what was done: the rebate that was never reported, the invoice that never reflected the real price, and the payment terms that nobody enforced because enforcing them would have required the practitioner to take any risk at all.

What the pitch sounds like

The pitch was rarely subtle. One Florida physician told the *New York Times* in 2025 how a wound care distributor described the deal to him: the distributor would "float out a percentage, it's usually 60/40 — they're getting 60, you're getting 40." See S. Kliff & K. Thomas, *Medicare Bleeds Billions on Pricey Bandages, and Doctors Get a Cut*, N.Y. Times (Apr. 10, 2025). The product's clinical profile did not come up. The split did.

And in the Apex Medical case in Arizona, the government alleged that the company's owners built an entire sales force around that pitch, paying untrained representatives to find elderly patients, many in hospice, and steering providers toward the largest and most expensive grafts available. The owners were sentenced in connection with what the Department of Justice described as a \$1.2 billion fraud and agreed to pay \$309 million to resolve civil claims. See DOJ Press Release, *Wound Graft Company Owners Sentenced in \$1.2B Health Care Fraud and Agree to Pay \$309M to Resolve Civil Liability* (2026).

Why it is illegal

A discount, by itself, is not a crime. The Anti-Kickback Statute contains a safe harbor for discounts that are properly disclosed and reflected in the price the provider reports to Medicare. See 42 U.S.C. § 1320a-7b(b)(3)(A); 42 C.F.R. § 1001.952(h). Marketing the spread fails that test by design. The discount is concealed, the invoice is inflated, and the point of the arrangement is to induce the provider to choose a product because of what it pays rather than what it does.

Under the law, the rebate becomes remuneration offered to induce the purchase of an item payable by a federal health care program, which the statute prohibits. See 42 U.S.C. § 1320a-7b(b)(2). And since 2010, Congress has made the connection to the False Claims Act explicit: a claim that includes items or services resulting from an Anti-Kickback Statute violation is a false claim. See 42 U.S.C. § 1320a-7b(g). Consequently, every Medicare claim the practice submitted for a graft purchased under the arrangement is therefore actionable under 31 U.S.C. § 3729(a)(1)(A), with treble damages and per-claim penalties.

The manufacturer carries separate exposure. If it reported an average sales price to CMS that did not reflect the rebates it was actually paying, it caused Medicare to set an inflated reimbursement rate for every provider in the country, not just the ones in on the deal. That is a classic caused-to-be-presented theory under 31 U.S.C. § 3729(a)(1)(A) and a false-record theory under § 3729(a)(1)(B).

Further, a spread case does not depend on proving that the grafts were medically unnecessary. The patient may have needed the graft. The claim is false anyway, because of how the graft was bought and billed. That makes these cases cleaner than medical necessity cases, which can devolve into a battle of experts.

What a whistleblower would have seen

Spread schemes leave a paper trail. If any of the following sounds familiar, you may have seen a False Claims Act violation:

- A sales deck, email, or text message that led with the practitioner's profit per application rather than clinical data
- A rebate, credit, or "marketing fee" that never appeared on the invoice the practice used to bill Medicare
- Payment terms, written or understood, that the manufacturer never enforced, because the practice always paid *after* Medicare did
- A practice that applied a particular graft only to Medicare patients, or that wrote off co-pays and never billed secondary insurers
- A manufacturer's reported average sales price that bore no resemblance to what the manufacturer was actually collecting

Sales representatives, distributors, billing managers, and office administrators see these things every day. Under the False Claims Act, a whistleblower whose case leads to a

recovery receives between 15% and 30% of what the government collects, see 31 U.S.C. § 3730(d), and the statute protects employees from retaliation for lawful efforts to stop a violation, see 31 U.S.C. § 3730(h).

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