Skin Substitute Cases: The Enforcement Wave

Three years ago, skin substitute fraud was merely a line item in an OIG data brief. Today it is one of the most active fronts in federal health care fraud enforcement, with billion-dollar criminal cases, nine-figure civil resolutions, and a steady stream of new indictments and qui tam complaints.

This post, the fourth in our series, surveys significant skin substitute and related wound care fraud cases. It is not exhaustive, and much of what follows comes from indictments and complaints, which contain allegations rather than findings. But read together, the cases show what the government is prioritizing, the kinds of evidence that have prompted enforcement actions, and where additional investigations may be headed.

The criminal cases

Apex Medical (D. Ariz.). The case that helped define the current enforcement wave. Alexandra Gehrke and Jeffrey King, a married couple who operated Arizona wound graft companies, pleaded guilty in a scheme that generated more than $1.2 billion in fraudulent claims to health insurance programs for amniotic allografts applied to elderly and terminally ill patients, many in hospice care. The government described sales representatives with no medical training who were paid to find patients with wounds and arrange for expensive, frequently oversized grafts, often without coordination with treating physicians. The scheme also involved hundreds of millions of dollars in kickbacks from a graft distributor. In October 2025, Gehrke was sentenced to fifteen and a half years in prison and King to fourteen years. In December 2025, they agreed to pay approximately $309 million to resolve civil False Claims Act liability. The civil settlements arose from qui tam allegations that remain under seal while investigations of other parties continue. The case illustrates the government's willingness to pursue not just the billing practitioners but those who organized and profited from the distribution network.

United States v. Yukee (S.D. Tex.). One of the largest alleged schemes involving an individual wound care practitioner. Marizel Yukee, a nurse practitioner who operated mobile wound care clinics in four states, was indicted in June 2026 on charges arising from approximately $906 million in claims to Medicare and TRICARE for allografts applied to elderly and hospice patients. Federal programs allegedly paid approximately $297 million. According to the indictment, the grafts were applied without appropriate conservative wound care, including to wounds that were infected, already healed, or otherwise unsuitable for treatment. Yukee allegedly solicited nearly $16 million in kickbacks from allograft distributors, paid kickbacks for patient referrals, and falsified records to make the treatments appear medically necessary. The government also

reported seizures of approximately $35.2 million in assets, including luxury jewelry and vehicles.

The June 2026 takedown. Yukee was among eleven wound care defendants charged as part of DOJ's 2026 National Health Care Fraud Takedown, which involved allegations of more than $2 billion in fraudulent wound care claims. The other cases illustrate how broadly the government is pursuing participants throughout the supply chain:

- **Brian Rowan (D. Ariz.)**, a sales executive, was indicted in an alleged $1.2 billion allograft scheme in which approximately $614 million was paid. Prosecutors alleged that Rowan directed kickbacks to sales representatives and providers through sham invoices and pass-through accounts, personally receiving more than $24 million.
- **Michael McMillan (N.D. Tex.)**, owner of the distributor Protectus, was charged with arranging for providers to use skin substitutes under an alleged scheme that guaranteed them profits from resulting claims, with improper payments disguised as rebates or discounts. The case involved approximately $268 million in alleged fraudulent payments by government programs. The allegations present a particularly clear example of what is sometimes called "marketing the spread"—using the difference between acquisition costs and reimbursement amounts to induce providers to use particular products.
- **Susie Kamien (D. Ariz.)**, a medical biller, was charged in connection with more than $918 million in allegedly fraudulent Medicare claims for amniotic wound allografts procured through kickbacks. The case demonstrates that the government's scrutiny extends beyond providers and distributors to those involved in the claims-submission process.
- **Leigh Tesar, Walter Presha Jr., and Koby Evans (M.D. Fla.)**, a nurse practitioner and two nurses, were indicted in an alleged $118 million scheme involving unnecessary wound allografts and referral kickbacks. Medicare allegedly paid approximately $61 million. Prosecutors charged that Presha and Evans were paid to refer Medicare patients to Tesar, who then billed for the grafts.
- **Casilda Muniz Rodriguez (S.D. Fla.)** was charged with organizing at least eleven clinics under nominee owners that allegedly billed Medicare more than $117 million for skin substitutes and wound care products never provided. In related enforcement activity, the government seized approximately $27.4 million from accounts associated with twelve South Florida clinics allegedly engaged in similar "bust-out" schemes.

Earlier and related prosecutions. The 2025 takedown charged a cluster of Arizona and Nevada defendants connected to the Apex network, including practitioners accused of applying grafts at frequencies directed by sales representatives. In Nevada, Paulino Gonzalez, a registered nurse, was charged in an alleged $94 million wound allograft scheme in which he received approximately $7.39 million in kickbacks from a distributor.

Other prosecutions have focused on unnecessary applications, unqualified providers, and billing for services never performed. These cases demonstrate that the enforcement effort encompasses both conventional medical-necessity fraud and newer schemes exploiting the unusually high reimbursement available for certain skin substitute products.

The civil cases

Vohra Wound Physicians (S.D. Fla.). In April 2025, the United States filed its own False Claims Act complaint, without a relator, against one of the country's largest wound care physician groups and its owner, Dr. Ameet Vohra. Unlike the skin substitute cases, Vohra principally involved billing for wound debridement procedures. The government alleged a nationwide practice of billing surgical excisional debridement that was unnecessary or never performed, driven by financial incentives and pressure to perform debridement at as many visits as possible. Particularly significant was the allegation that Vohra's electronic health record and billing software were programmed to bill the higher-paying surgical code regardless of the procedure actually performed, while creating supporting documentation. In November 2025, Vohra and its owner agreed to pay $45 million and entered a five-year Corporate Integrity Agreement that includes independent review of the company's health information technology systems. The case is notable both for its relatively quick resolution after the complaint was filed and for the government's attention to software designed to generate or support improper claims.

Aronowitz (C.D. Cal.). Dr. Joel Aronowitz and his Beverly Hills medical practice resolved allegations involving improper billing for skin substitute products, including claims for procedures performed at ineligible locations, multiple billings for single-use products, and reuse of products across patients. The settlement totaled nearly $24 million. Aronowitz and Tower Multi-Specialty Medical Group also agreed to a fifteen-year exclusion from participation in federal health care programs. The case illustrates that claims involving skin substitutes can be false even where a product was actually used, if the location, quantity, or manner of application does not support the reimbursement claimed.

Blanck / Valley View Foot and Ankle Center (E.D. Okla.). In April 2023, podiatrist Bryan Andrew Blanck agreed to pay $7 million to resolve allegations that he submitted false claims to federal veterans' health care programs for excessive medical services and services billed at higher levels than were medically reasonable or necessary in connection with bioengineered skin substitutes and related wound care. The allegations concerned claims submitted to the VA Choice and Patient-Centered Community Care programs, rather than Medicare. The case illustrates that skin substitute enforcement is not confined to Medicare and can involve excessive services and improper billing levels as well as the medical necessity of the underlying treatment.

Heartland Plastic & Reconstructive Surgery (S.D. Iowa). Filed as part of the June 2026 takedown, this civil False Claims Act complaint names plastic surgeon Dr. Eugene Cherny and his practice, Heartland Plastic & Reconstructive Surgery. It alleges an invoice-pricing scheme in particularly direct form: Cherny allegedly obtained two invoices for each skin substitute product, one showing the price actually paid and the other an artificially inflated list price. When a Medicare contractor requested invoices to substantiate reimbursement, he allegedly submitted only the inflated versions. Federal programs allegedly paid more than $2 million. The case demonstrates how a false representation of acquisition cost can generate FCA liability independently of whether a graft was medically necessary or actually applied.

Advanced BioHealing (M.D. Fla.). An earlier and influential skin substitute kickback case provides important historical context. *United States ex rel. Vinca v. Advanced BioHealing, Inc.*, No. 8:11-cv-00176 (M.D. Fla.), was the first-filed of six qui tam actions alleging that the manufacturer of Dermagraft paid kickbacks and used other unlawful inducements to encourage providers to use or overuse its product. In January 2017, Shire plc subsidiaries, including entities associated with Advanced BioHealing, agreed to pay $350 million to resolve federal and state False Claims Act allegations. The related qui tam litigation also produced disputes over competing relators' entitlement to settlement proceeds, illustrating the significance of first-to-file issues when multiple whistleblowers report overlapping misconduct. We will return to those issues in the next post.

What the cases have in common

Read together, the cases reveal several recurring patterns.

The money follows the kickback. Many of the largest criminal cases center on financial arrangements that allegedly induced providers to order expensive skin substitutes. The grafts may also have been unnecessary or improperly billed, but the kickback allegations often explain how the schemes operated: rebates that concealed improper remuneration, referral fees, guaranteed-profit arrangements, sham invoices, and pass-through accounts. The McMillan prosecution is particularly significant because it illustrates how arrangements built around the difference between product acquisition costs and reimbursement amounts can become the subject of criminal charges.

Hospice patients are a recurring warning sign. Apex, Yukee, and several related prosecutions involved grafts applied to terminally ill patients, often without appropriate wound assessment, conservative treatment, or coordination with treating physicians. Hospice status alone does not establish that a wound treatment is inappropriate. But the patient's prognosis, the characteristics of the wound, the likelihood of clinical benefit, and the documented rationale for an expensive graft are important to the medical-necessity analysis. Where the treatment has little prospect of providing a meaningful benefit, repeated applications of costly grafts may warrant particular scrutiny.

Nurse practitioners and other nonphysician providers frequently appear in the billing chain. Yukee, Tesar, Gonzalez, and several Arizona defendants were nurses or nurse practitioners. The recurring model involves mobile wound care operations, patients located or referred by sales representatives, and expensive products ordered or applied by providers who may have financial relationships with distributors. The relevant questions include who actually selected the treatment, who exercised clinical judgment, who received financial benefits, and whether the billing provider personally performed or appropriately supervised the services claimed.

The government is pursuing the entire supply chain. Earlier cases already reached company owners and intermediaries, but the 2026 takedown underscores the breadth of enforcement against sales executives, distributors, medical billers, clinic organizers, and treating practitioners. The allegations increasingly address not only who submitted a claim but also who structured the financial incentives, selected the products, generated the documentation, and facilitated the billing. The Apex civil settlement arose from qui tam allegations that remain under seal while investigations of other parties continue, suggesting that additional enforcement activity may follow.

Software and documentation are evidence. In Vohra, the government alleged that the EHR was programmed to default to higher-reimbursed surgical procedures and generate supporting documentation. In Yukee, prosecutors alleged that records were falsified to make treatments appear medically necessary. These allegations illustrate that investigators are examining not simply whether a patient's chart contains the required language, but how that language was generated, whether it reflects the care actually provided, and whether billing systems were designed to produce predetermined results. Templated documentation that tracks Medicare coverage criteria may become evidence of knowing misconduct when it systematically misrepresents the underlying clinical facts.

Pricing records matter as much as medical records. The Heartland allegations emphasize a different category of evidence: invoices, purchasing records, distributor contracts, rebates, and other records showing what providers actually paid for products. Where reimbursement depends on reported acquisition costs, the difference between a list price and the true net price may be central to an FCA investigation. Those records can also reveal financial incentives that do not appear in a patient's medical chart.

Some cases resolve quickly after filing. Vohra's $45 million settlement came approximately seven months after the government's complaint. That timing does not establish how long the underlying investigation lasted, and other cases have proceeded for years. It nevertheless demonstrates that a substantial civil resolution can follow relatively quickly once the government files a developed complaint supported by billing data, software records, and internal documents.

What it means for a potential whistleblower

Two things stand out from this survey for anyone who has seen this conduct firsthand.

First, the government is actively pursuing the people above and around the practitioner: the distributors, sales organizations, billers, manufacturers, and clinic operators who may have designed or facilitated the incentive structures. The Apex civil settlement arose from sealed qui tam allegations, and DOJ has stated that investigations of other parties are continuing. Insiders at these companies may have access to precisely the kinds of evidence that are difficult to obtain from claims data alone: communications about provider compensation, actual product acquisition costs, rebate arrangements, sales instructions, internal audits, and decisions about how claims should be documented or coded.

Second, timing can matter. The False Claims Act's first-to-file rule, 31 U.S.C. § 3730(b)(5), generally prevents a new qui tam action based on the facts underlying a related action that is already pending. Separately, the public disclosure bar, § 3730(e)(4), may require dismissal when substantially the same allegations or transactions have already been disclosed through specified public channels, subject to statutory exceptions, including for original sources. Indictments, court proceedings, and public announcements may therefore affect the viability of later whistleblower claims.

Public disclosure does not, however, automatically foreclose a subsequent qui tam action. A whistleblower with independent knowledge that materially adds to publicly disclosed information may still qualify as an original source, and a previously filed action does not necessarily bar a later suit after it is no longer pending. The analysis depends on the particular allegations, the timing of the cases, and the information the whistleblower can provide. For someone with firsthand evidence of an ongoing scheme, an early legal assessment can be important.

The financial incentives for whistleblowers can also be substantial. Under the False Claims Act, a successful relator generally may receive between 15% and 25% of the recovery when the government intervenes, or between 25% and 30% when the government declines to intervene and the relator successfully pursues the action, subject to statutory qualifications and exceptions. 31 U.S.C. § 3730(d). The Act also protects employees, contractors, and agents from retaliation for lawful efforts to stop violations. 31 U.S.C. § 3730(h).

The cases surveyed here show why information from insiders can be important. Billing data may reveal unusually high utilization, repeated graft applications, or extraordinary reimbursement amounts. But the underlying contracts, communications, purchasing records, and clinical documentation may reveal why those claims were submitted—and whether the conduct resulted from mistake, aggressive but lawful business practices, or knowing fraud.

If you have information about conduct like this, we may be able to help. Pollock Cohen represents whistleblowers in False Claims Act matters nationwide, and consultations are confidential and without charge. You can contact us.

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