DOJ National Fraud Enforcement Division press release, 2026-10-23
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Telemedicine Company Owner Sentenced to 20 Years in Prison for $46M Medicare Fraud Scheme

The owner of a telemedicine company was sentenced today to 20 years in prison for organizing and leading a $46.2 million Medicare fraud conspiracy that spanned more than six years. In addition to the prison term, the defendant was ordered to pay $17,942,402 in restitution to Medicare and $10,431,463 in forfeiture.

According to court documents, Christopher Harwood, 44, of Fort Lauderdale, Florida, owned and operated a telemedicine company called TelevisitMD. Harwood 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.

Harwood paid doctors to approve orders for orthotic 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. Harwood then sold the signed doctors' orders to durable medical equipment (DME) supply companies, laboratories, and marketers who were part of the scheme.

Harwood 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, Harwood caused $46.2 million in false and fraudulent claims to Medicare, and Medicare paid $17.9 million based on those claims. Harwood personally profited more than $10.4 million from the fraud scheme.

In March 2026, Harwood pleaded guilty to conspiracy to commit health care fraud and wire fraud.

Assistant Attorney General Colin M. McDonald of the Justice Department's National Fraud Enforcement Division; U.S. Attorney Jason A. Reding Quiñones for the Southern District of Florida; Special Agent in Charge Brett Skiles of the FBI

Miami Field Office; and Acting Deputy Inspector General for Investigations Miranda Bennett of the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) made the announcement.

FBI and HHS-OIG investigated the case.

Trial Attorney Owen Dunn of the Fraud Division's Health Care Fraud Section is prosecuting the case.

On April 7, the Department of Justice announced the creation of the Fraud Division. The Fraud Division is laser-focused on investigating and prosecuting those who commit fraud against the American people. The Department's work to combat fraud supports President Trump's Task Force to Eliminate Fraud, a whole-of-government effort chaired by Vice President J.D. Vance to eliminate fraud, waste, and abuse within Federal benefit programs.

The Department of Justice's Health Care Fraud Strike Force Program, currently comprised of nine strike forces operating in federal districts across the country, has charged more than 6,200 defendants who collectively billed federal health care programs and private insurers more than $45 billion since 2007. In addition, the Centers for Medicare & Medicaid Services, working in conjunction with the Office of the Inspector General for the Department of Health and Human Services, are taking steps to hold providers accountable for their involvement in health care fraud schemes. More information can be found at www.justice.gov/criminal-fraud/health-care-fraud-unit .