ORIGINAL

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

UNITED STATES OF AMERICA

v.

DANIEL R. CANCHOLA, M.D. (01)

Criminal No. 19-CR-473

SUPERSEDING INDICTMENT

The Grand Jury charges that:

General Allegations

At all times material to this superseding indictment,

The Defendant and Related Entities

1. In or around the charged period, defendant **Daniel Canchola**, a resident of Flower Mound, Texas, was a licensed physician who signed prescriptions and other Medicare-required documents for certain tests and medical devices, as **Daniel Canchola** knew and intended, that were, among other things, not legitimately prescribed, not needed, not used, or induced through unlawful kickbacks and bribes.

2. In or around the charged period, Company A and Company B were limited liability companies organized under the laws of the State of Florida purportedly providing telemedicine and staffing services.

3. In or around the charged period, Person A and Person B owned and operated Company A and Company B.

The Medicare Program

4. The Medicare Program ("Medicare") was a federal health care program providing benefits to individuals who were the age of 65, or older, or disabled. The benefits available under Medicare were governed by federal statutes and regulations. Individuals who received benefits under Medicare were commonly referred to as Medicare "beneficiaries."

5. Medicare was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b) and a "Federal health care program," as defined by Title 42, United States Code, Section 1320a-7b(f).

6. Medicare covered, among other things, medical services provided by physicians, medical clinics, laboratories, and other qualified health care providers, and office services and outpatient care—including the ordering of durable medical equipment, prosthetics, orthotics, and supplies ("DME")—that were medically necessary and ordered by licensed medical doctors or other qualified health care providers.

7. Physicians, clinics, laboratories, and other health care providers that provided services to Medicare beneficiaries were able to apply for and obtain a "provider number." A health care provider that received a Medicare provider number was able to file claims with Medicare to obtain reimbursement for services provided to beneficiaries.

8. To receive Medicare reimbursement, providers had to apply and execute a written provider agreement, known as CMS Form 855. The Medicare application was required to be signed by an authorized representative of the provider. The application contained certifications that the provider agreed to abide by the Medicare laws and

regulations, including the Anti-Kickback Statute, and that the provider "will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity."

Cancer Genomic Tests

9. Cancer genomic ("CGx") testing used DNA sequencing to detect mutations in genes that could indicate a higher risk of developing certain types of cancers in the future. CGx testing was not a method of diagnosing whether an individual presently had cancer.

10. Medicare did not cover diagnostic testing that was "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Title 42, United States Code, Section 1395y(a)(1)(A). Except for certain statutory exceptions, Medicare did not cover "examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint or injury." Title 42, Code of Federal Regulations, Section 411.15(a)(1). Among the statutory exceptions Medicare covered were cancer screening tests such as "screening mammography, colorectal cancer screening tests, screening pelvic exams, [and] prostate cancer screening tests." *Id.*

11. If diagnostic testing were necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, Medicare imposed additional requirements before covering the testing. Title 42, Code of Federal Regulations, Section 410.32(a) provided, "All diagnostic x-ray tests, diagnostic

laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem." "Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary." *Id.*

12. Because CGx testing did not diagnose cancer, Medicare only covered such tests in limited circumstances, such as when a beneficiary had cancer and the beneficiary's treating physician deemed such testing necessary for the beneficiary's treatment of that cancer. Medicare did not cover CGx testing for beneficiaries who did not have cancer or lacked symptoms of cancer.

Durable Medical Equipment

13. Medicare covered an individual's access to DME, such as off-the-shelf ("OTS") ankle braces, knee braces, back braces, elbow braces, wrist braces, and hand braces (collectively, "braces"). OTS braces require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit the individual.

14. A claim for DME submitted to Medicare qualified for reimbursement only if it was medically necessary for the treatment of the beneficiary's illness or injury and prescribed by a licensed physician.

15. For certain DME products, Medicare promulgates additional requirements that a DME order must meet for an order to be considered "reasonable and necessary." For example, for OTS knee braces billed to Medicare under the Healthcare Common

Procedures Coding System ("HCPCS") Codes L1833 and L1851, an order will be deemed "not reasonable and necessary" and reimbursement will be denied unless the ordering/referring physician documents the beneficiary's knee instability using an objective description of joint laxity determined through a physical examination of the beneficiary.

Telemedicine

16. Telemedicine provided a means of connecting patients to doctors by using telecommunications technology to interact with a patient.

17. Legitimate telemedicine companies provided telemedicine services to individuals by hiring doctors and other health care providers. Legitimate telemedicine companies typically paid doctors a fee to conduct consultations with patients. In order to generate revenue, legitimate telemedicine companies typically either billed insurance or received payment from patients who utilized the services of the telemedicine company.

18. Medicare covered expenses for specified telemedicine services if certain requirements were met. These requirements included, but were not limited to, that (a) the beneficiary was located in a rural or health professional shortage area; (b) services were delivered via a two-way, real-time interactive audio and video telecommunications system; and (c) the beneficiary was at a practitioner's office or a specified medical facility – not at a beneficiary's home – during the telemedicine consultation with a remote practitioner.

The Fraudulent Scheme

Overview of the Scheme

19. **Daniel Canchola** unlawfully caused to be submitted false and fraudulent claims to federal health care benefit programs for prescriptions for CGx tests and DME without examining or speaking to patients and without any physician-patient relationship. Federal health care benefit programs paid over a hundred million dollars on these false and fraudulent claims. These completed, signed prescriptions for CGx testing or DME and other Medicare-required documents (collectively referred to as "doctors' orders"), as **Daniel Canchola** knew and intended, were, among other things, not legitimately prescribed, not needed, not used, or induced through unlawful kickbacks and bribes.

20. Over the course of, and in furtherance of, the fraudulent scheme, which began no later than in or about May 2018 and continued until in or about November 2019, the exact dates being unknown to the Grand Jury, **Daniel Canchola**, and others known and unknown to the Grand Jury, caused the submission of false and fraudulent claims to Medicare for CGx testing and DME that were not legitimately prescribed, not needed, not used, or induced through unlawful kickbacks and bribes, in at least the approximate amount of $125.7 million, via interstate wire communication.

Object/Purpose of the Scheme

21. The object/purpose of the scheme was for **Daniel Canchola**, his co-conspirators Person A and Person B, and others known and unknown to the Grand Jury, to unlawfully enrich themselves by, among other things: (a) paying and receiving kickbacks and bribes in exchange for signed doctors' orders for CGx testing or DME that

were not legitimately prescribed, not needed, not used, or induced through unlawful kickbacks and bribes; and (b) submitting and causing the submission via interstate wire communication of false and fraudulent claims to Medicare for CGx testing and DME that were not medically necessary and not eligible for reimbursement.

Execution of the Scheme

22. Beginning in or about May 2004, **Daniel Canchola**, as a Medicare provider, promised to comply with all Medicare rules and regulations, including that he would refrain from violating the federal Anti-Kickback Statute.

23. For all times during the charged period, **Daniel Canchola** was a Medicare provider and was required to abide by all Medicare rules and regulations and federal laws, including that he would not knowingly present or cause to be presented a false and fraudulent claim for payment by Medicare and that he would comply with the Anti-Kickback Statute.

24. **Daniel Canchola** worked as an independent contractor for Person A and Person B. Specifically, **Daniel Canchola** worked with Company A and Company B, through Person A and Person B, to sign doctors' orders for CGx testing or DME that were used to submit false and fraudulent claims to Medicare.

25. **Daniel Canchola** received unsigned prescriptions for CGx testing or DME, which were transmitted via email from Person A, Person B, and others acting on behalf of Company A and Company B to **Daniel Canchola** to sign.

26. **Daniel Canchola** electronically signed doctors' orders for CGx testing or DME for Medicare beneficiaries (a) without seeing, speaking to, or otherwise

communicating with or examining them; and (b) without regard to whether beneficiaries needed the CGx testing or DME.

27. **Daniel Canchola** was not treating the beneficiaries for which he signed doctors' orders for CGx testing for cancer or symptoms of cancer, and he did not use the test results in the treatment of beneficiaries.

28. **Daniel Canchola** was not treating and did not examine the beneficiaries for which he signed doctors' orders for DME. Despite this, **Daniel Canchola** signed a certification that stated: "I . . . certify that I have personally performed the assessment of the patient for the prescribed treatment and device and verify that it is reasonable and medically necessary, according to accepted standards of medical practice within the community, for this patient's medical conditions."

29. **Daniel Canchola** electronically signed doctors' orders for CGx testing or DME while traveling internationally and without seeing, speaking to, or otherwise communicating with or examining the beneficiaries.

30. **Daniel Canchola** created invoices to track the number of beneficiaries for whom he had signed doctors' orders for CGx testing or DME. **Daniel Canchola** sent the invoices to Person A and Person B, requesting approximately $30 per signed doctors' order.

31. Person A and Person B, through Company A and Company B, paid illegal kickbacks and bribes to **Daniel Canchola** in exchange for signing doctors' orders for CGx testing or DME.

32. **Daniel Canchola** used his BBVA Compass Bank account number ending x882 for the purpose of, among other things, receiving illegal kickbacks and bribes from Company A and Company B in exchange for signing doctors' orders for CGx testing or DME.

33. The Medicare beneficiaries for whom **Daniel Canchola** signed doctors' orders for CGx testing or DME were targeted by telemarketing campaigns and at health fairs, and they were induced to submit to CGx testing and to receive DME, regardless of medical necessity.

34. In furtherance of the scheme, and to accomplish its purpose, the conspirators submitted and caused to be submitted the false and fraudulent claims reflected in Counts Two through Seven.

COUNT ONE

Conspiracy to Commit Health Care Fraud and Wire Fraud
(Violation of 18 U.S.C. § 1349 (18 U.S.C. §§ 1347 and 1343))

35. The Grand Jury re-alleges and incorporates by reference all previous paragraphs as if fully alleged herein.

The Conspiracy

36. From in or about May 2018 and continuing to in or about November 2019, the exact dates being unknown to the Grand Jury, in the Dallas Division of the Northern District of Texas and elsewhere, **Daniel Canchola** did knowingly and willfully combine, conspire, confederate, and agree with Person A, Person B, and other persons known and unknown to the Grand Jury, to commit offenses against the United States, that is:

a. to knowingly and willfully execute a scheme and artifice to defraud a health care benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), that is, Medicare, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, said health care benefit program, in connection with the delivery of and payment for health care benefits, items, or services, in violation of Title 18, United States Code, Section 1347; and

b. to knowingly devise or intend to devise a scheme and artifice to defraud, by means of materially false and fraudulent pretenses, representations, and promises, did transmit and cause to be transmitted by means of wire communication in interstate and foreign commerce, any writings, signs, signals, pictures, and sounds, in violation of Title 18, United States Code, Section 1343,

all in violation of 18 U.S.C. § 1349.

The Object/Purpose of the Conspiracy

37. The Grand Jury re-alleges and incorporates paragraph 21 as a description of the object/purpose of the conspiracy.

The Manner and Means of the Conspiracy

38. In furtherance of the conspiracy and to accomplish its object/purpose, the methods, manners, and means that were used are described in paragraphs 19 through 34, and incorporated by reference as though set forth fully therein.

COUNTS TWO THROUGH SEVEN
Health Care Fraud
(Violation of 18 U.S.C. §§ 1347 and 2)

39. The Grand Jury re-alleges and incorporates by reference all previous paragraphs as if fully alleged herein.

40. From in or about May 2018 and continuing to in or about November 2019, the exact dates being unknown to the Grand Jury, in the Dallas Division of the Northern District of Texas and elsewhere, **Daniel Canchola** did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud Medicare, a health care benefit program affecting commerce as defined in 18 U.S.C. § 24(b), and to obtain by means of materially false and fraudulent pretenses, representations, and promises, in connection with the delivery of, and payment for, health care benefits, items, or services, by submitting or causing the submission of, false and fraudulent claims to Medicare for CGx testing and DME, that were, among other things, not legitimately prescribed, not needed, not used, or induced through unlawful kickbacks.

41. On or about the dates specified below, in the Dallas Division of the Northern District of Texas, and elsewhere, **Daniel Canchola**, aided and abetted by others, and aiding and abetting others known and unknown to the Grand Jury, caused to be submitted the following false and fraudulent claims to Medicare for CGx testing and DME, via interstate wire communication, that were, among other things, not legitimately prescribed, not needed, not used, or induced through unlawful kickbacks, in execution of the scheme described in Paragraph 40, with each claim forming a separate count as outlined in the below two tables:

Count	Medicare Beneficiary	Approx. Date	Claim No.	Approx. Total Amount Billed	Fraudulent test listed in claim; HCPCS Code
TWO	D.M.	7/28/2018	531118250284460	$23,968.00	Gene analysis (adenomatous polyposis coli), full gene sequence; 81201
THREE	W.W.	8/7/2018	531118250284120	$23,968.00	Gene analysis (adenomatous polyposis coli), full gene sequence; 81201
FOUR	C.H.	11/12/2018	531119008478640	$8,373.18	Gene analysis (adenomatous polyposis coli), full gene sequence; 81201
FIVE	I.V.	12/3/2018	531119002328520	$11,264.00	Gene analysis (adenomatous polyposis coli), full gene sequence; 81201

Count	Medicare Beneficiary	Approx. Date	Claim No.	Approx. Total Amount Billed	Description of Devices Billed; HCPCS Code
SIX	T.F.	8/16/2018	18249712681000	$971.23	Left knee orthosis (L1851); Addition to lower extremity orthosis, suspension sleeve (L3297)
SEVEN	A.B.	2/22/2019	19057709310000	$1,707.82	Right knee orthosis (L1851); Left knee orthosis (L1851); Addition to lower extremity orthosis, suspension sleeve (L3297)

all in violation of 18 U.S.C. §§ 1347 and 2.

Forfeiture Notice
(18 U.S.C. §§ 981(a)(1)(C) and 982(a)(7) and 28 U.S.C. § 2461(c))

42. Pursuant to 18 U.S.C. § 981(a)(1)(C) and 28 U.S.C. § 2461(c), upon conviction of Count One, the defendant, **Daniel Canchola,** shall forfeit to the United States, any property, real or personal, which constitutes or is derived from proceeds traceable to the violation.

43. Pursuant to 18 U.S.C. § 982(a)(7), upon conviction of Counts Two through Seven, the defendant, **Daniel Canchola,** shall forfeit to the United States, any property, real or personal, which constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

44. Pursuant to 21 U.S.C. § 853(p), as incorporated by 28 U.S.C. § 2461(c), if any of the property described above, as a result of any act or omission of a defendant:

a. cannot be located upon the exercise of due diligence;

b. has been transferred, sold to, or deposited with, a third party;

c. has been placed beyond the jurisdiction of the court;

d. has been substantially diminished in value; or

e. has been commingled with other property which cannot be divided without difficulty,

the United States intends to seek forfeiture of any other property of the defendant up to the value of the forfeitable property described above.

A TRUE BILL

FOREPERSON

ERIN NEALY COX
UNITED STATES ATTORNEY

ROBERT ZINK
U.S. Department of Justice
Criminal Division, Fraud Section
Chief

ALLAN J. MEDINA
U.S. Department of Justice
Criminal Division, Fraud Section
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FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

THE UNITED STATES OF AMERICA

v.

DANIEL CANCHOLA, M.D. (01)

SUPERSEDING INDICTMENT

18 U.S.C. § 1349 (18 U.S.C. §§ 1347 and 1343))
Conspiracy to Commit Health Care Fraud and Wire Fraud
(Count 1)

18 U.S.C. §§ 1347 and 2
Health Care Fraud
(Counts 2-7)

18 U.S.C. §§ 981(a)(1)(C), 982(a)(7) and 28 U.S.C. § 2461(c)
Forfeiture Notice

7 Counts

A true bill rendered

DALLAS FOREPERSON

Filed in open court this 26 day of February, 2020.

No Warrant Needed

UNITED STATES MAGISTRATE JUDGE

No Criminal Matter Pending