UNITED STATES DISTRICT COURT

MIDDLE DISTRICT OF LOUISIANA

INDICTMENT FOR
CONSPIRACY TO COMMIT HEALTH CARE FRAUD,
HEALTH CARE FRAUD, AND FORFEITURE ALLEGATIONS

UNITED STATES OF AMERICA	:	CRIMINAL NO. 19- 114-JWD-RLD
	:	
versus	:	18 U.S.C. § 1349
	:	18 U.S.C. § 1347
J. FOSTER CHAPMAN, D.O.	:	18 U.S.C. § 2
	:	18 U.S.C. § 982(a)(7)
	:	21 U.S.C. § 853(p)

THE GRAND JURY CHARGES:

AT ALL TIMES RELEVANT TO THIS INDICTMENT:

The Medicare Program

1. The Medicare Program ("Medicare") was a federal health insurance program, affecting commerce, that provided benefits to persons who were 65 years of age and older or disabled.

2. Medicare was a "health care benefit program" within the meaning of Title 18, United States Code, Section 24(b), and a "Federal health care program" within the meaning of Title 42, United States Code, Section 1320a-7b(f).

3. Medicare was administered by the United States Department of Health and Human Services, through its agency, the Centers for Medicare and Medicaid Services.

4. Individuals who qualified for Medicare benefits were commonly referred to as "beneficiaries." Each beneficiary was given a unique Medicare identification number.

5. As part of the Medicare enrollment process, health care providers, including physicians ("providers"), submitted enrollment applications to Medicare. To participate in Medicare, providers were required to certify that they would comply with all Medicare-related laws, rules, and regulations. If Medicare approved a provider's application, Medicare assigned the provider a Medicare provider number. A provider with a Medicare provider number could submit claims to Medicare to obtain reimbursement for medically necessary items and services rendered to beneficiaries. Medicare providers were given access to Medicare manuals and service bulletins describing procedures, rules, and regulations.

6. When seeking reimbursement from Medicare, providers submitted the cost of the service provided together with the appropriate "procedure code," as set forth in the Current Procedural Terminology Manual or the Healthcare Common Procedure Coding System ("HCPCS").

7. Medicare included coverage under component parts. Medicare Part B covered, among other things, physician services, outpatient care, and durable medical equipment.

Durable Medical Equipment

8. Durable medical equipment ("DME") was reusable medical equipment such as orthotic devices, walkers, canes, or hospital beds. Orthotic devices were a type of DME that included knee braces, back braces, shoulder braces, and wrist braces (collectively, "braces"), as well as orthotic sleeves.

9. Medicare reimbursed DME providers for medically necessary items and services rendered to beneficiaries. In claims submitted to Medicare for the reimbursement of provided DME, providers were required to set forth, among other information, the beneficiary's name and unique Medicare identification number, the equipment provided to the

beneficiary, the date the equipment was provided, the cost of the equipment, and the name and provider number of the provider who prescribed or ordered the equipment.

10. Medicare would pay claims for the provision of DME only if the equipment was ordered by a licensed provider, was reasonable and medically necessary for the treatment of the diagnosed and covered condition, and was actually provided to beneficiaries. For certain types of orthotics, such as knee braces billed under procedure code L1833, Medicare Local Coverage Determinations ("LCDs") required that a provider conduct an in-person examination of a beneficiary. According to the LCDs, knee braces ordered without an in-person examination were not medically necessary. Medicare claims were required to be properly documented in accordance with Medicare rules and regulations. Medicare would not reimburse providers for claims that were procured through the payment of kickbacks and bribes.

Telemedicine

11. Telemedicine was a means of remotely connecting patients to health care providers by using telecommunication technology, such as the internet or a telephone.

12. Medicare deemed telemedicine an appropriate means to provide certain health care related services ("telehealth services") to beneficiaries, including, among other services, consultations and office visits, only when certain requirements were met. These requirements included, among others: (a) that the beneficiary was located in a rural area (outside a Metropolitan Statistical Area or in a rural health professional shortage area); (b) that the services were delivered via an interactive audio and video telecommunications system; and (c) that the beneficiary was at a practitioner's office or a specified medical facility—not at a beneficiary's home—during the telehealth service furnished by a remote provider.

13. Telehealth services could be covered by and reimbursable under Medicare, but only if telemedicine was generally appropriate, as outlined above, and only if the services were both ordered by a licensed provider and were reasonable and medically necessary to diagnose and treat a covered illness or condition.

14. Legitimate telemedicine companies employed providers to furnish telehealth services, including consultations, to individuals, often paying salaries to these employees. Telemedicine companies, typically, in turn, submitted claims to Medicare for telehealth services provided by employees to beneficiaries. Alternatively, some telemedicine companies paid a fee to providers each time a provider submitted an order for DME.

The Defendant, Relevant Entities, and Relevant Individuals

15. The defendant, **J. FOSTER CHAPMAN, D.O.**, a resident of Alexandria, Louisiana, was a medical doctor licensed to practice medicine in Louisiana. **CHAPMAN**, in 2015, applied for and obtained a Medicare provider number, and in doing so, agreed to abide by all the terms, laws, and regulations of Medicare. **CHAPMAN** worked as an independent contractor, typically through staffing companies, for various purported telemedicine companies.

16. Company 1, a company known to the Grand Jury, was a foreign corporation located in the Philippines. Company 1 owned and operated call centers in the Philippines and elsewhere.

17. Company 2, a company known to the Grand Jury, was a foreign company located in the Philippines. Company 2 owned and operated call centers in the Philippines and elsewhere.

18. Company 3, a company known to the Grand Jury, was a Florida for-profit company registered on August 27, 2013. Company 3 operated as a purported telemedicine company.

19. Company 4, a company known to the Grand Jury, was a Florida for-profit corporation registered on August 28, 2017. Company 4 operated as a purported telemedicine company.

20. Company 5, a company known to the Grand Jury, was a Georgia for-profit corporation registered on February 20, 2002. Company 5 provided staffing services to various purported telemedicine companies, including Company 4. Company 5 contracted with **CHAPMAN** to provide purported telehealth services to beneficiaries on behalf of various telemedicine companies, including Company 4.

21. H.B. was a beneficiary residing in the Middle District of Louisiana.

22. G.B. was a beneficiary residing in the Middle District of Louisiana.

23. A.A. was a beneficiary residing in the Middle District of Louisiana.

24. R.L. was a beneficiary residing in the Middle District of Louisiana.

The Fraudulent Scheme

Overview of the Scheme

25. **CHAPMAN** and others agreed to execute and executed a scheme whereby they submitted and caused to be submitted over $4.8 million in false and fraudulent claims to Medicare for medically unnecessary DME, including knee braces, for which Medicare reimbursed over $1.7 million.

26. Specifically, and contrary to Medicare LCDs which require an in-person examination of the patient, **CHAPMAN** ordered knee braces for beneficiaries who he had not

examined and who had not been examined by a licensed physician. These orders, as **CHAPMAN** knew, were (a) induced in part by the payment of kickbacks; (b) not medically necessary; and (c) not the product of a doctor-patient relationship and examination.

Purpose of the Scheme

27. The purpose of the scheme was for **CHAPMAN** and others known and unknown to the Grand Jury to unlawfully enrich themselves by:

a. offering, paying, soliciting, and receiving kickbacks and bribes in exchange for the furnishing and arranging for the furnishing, and arranging and recommending the purchasing and ordering of, DME to beneficiaries by various DME providers;

b. shipping and delivering medically unnecessary DME to beneficiaries via the United States Postal Service and private or commercial carriers (collectively, "the carriers");

c. submitting and causing the submission of false and fraudulent claims to Medicare, including for services purportedly rendered to beneficiaries located in the Middle District of Louisiana and elsewhere;

d. receiving and obtaining the reimbursements paid by Medicare based on the false and fraudulent claims submitted; and

e. concealing the offering, paying, soliciting, and receiving of kickbacks and bribes, the shipping and delivering of medically unnecessary DME via carriers, and the submission of false and fraudulent claims to Medicare.

Manner and Means of the Scheme

28. Beginning at least as early as September 2016, Company 1, Company 2, and other companies advertised, through television, internet, telephone, and direct mailings, in the United States, including in the Middle District of Louisiana, that beneficiaries suffering from back, joint, knee, and other pain were eligible to receive DME, namely, braces, at low or no cost to the beneficiaries. These companies further advertised toll-free numbers for beneficiaries to call and inquire about the advertised DME.

29. Upon beneficiaries calling the advertised toll-free numbers, or receiving a call from a call center, the beneficiaries, including those located in the Middle District of Louisiana, spoke with representatives of call centers owned and operated by Company 1, Company 2, and other companies that solicited beneficiaries, through high-pressure sales tactics, to receive a variety of DME that beneficiaries neither wanted nor needed. Call center representatives typically indicated that a provider would be in contact with the beneficiaries to further discuss with beneficiaries the items provided.

30. Upon beneficiaries providing personal information, including their names and unique Medicare identification numbers ("personally identifiable information"), to representatives of the call centers, the call centers, in turn, provided that information to purported telemedicine companies, including Company 3 and Company 4.

31. Purported telemedicine companies, including Company 3 and Company 4, utilized providers to prescribe DME to beneficiaries. Routinely, providers did not contact the beneficiaries. Instead, often without examining the beneficiaries and determining medical necessity, via telemedicine or otherwise, and in exchange for referral fees, providers prescribed DME to beneficiaries that was not medically necessary ("fraudulent orders").

32. **CHAPMAN**, for his part, electronically signed fraudulent orders for DME, including for beneficiaries located in the Middle District of Louisiana, such as beneficiaries H.B., G.B., A.A., and R.L., regardless of medical necessity, in the absence of a pre-existing doctor-patient relationship, without a physical examination, and frequently based solely on a short telephone conversation or no conversation at all.

33. These fraudulent orders were based on information derived, among other things, from telephone conversations between beneficiaries and employees of call centers, including Company 1, Company 2, and others, who were not trained medical professionals. These telephone conversations were recorded and made available to **CHAPMAN**, and the information derived therefrom formed the basis of the fraudulent orders.

34. **CHAPMAN** further concealed and disguised the scheme by preparing or causing to be prepared false and fraudulent documentation, and/or submitting or causing the submission of false and fraudulent documentation to Medicare. Specifically, **CHAPMAN** submitted and/or caused to be submitted false and fraudulent documents certifying that he had consulted with the beneficiaries and conducted various examinations and diagnostic tests prior to ordering DME, when, in fact, **CHAPMAN** never saw the beneficiaries face-to-face; had either a brief telephone conversation with these beneficiaries or none at all; and did not conduct the identified examinations and tests.

35. **CHAPMAN** submitted orders for DME on behalf of beneficiaries residing in the Middle District of Louisiana, and elsewhere, which caused claims to be submitted to Medicare for services rendered to such beneficiaries.

36. Purported telemedicine companies, including Company 3 and Company 4, in turn, provided the fraudulent orders to Company 1, Company 2, and other companies, which

then delivered the fraudulent orders to various DME providers located across the United States, including DME providers located in the Middle District of Louisiana.

37. The various DME providers, based on the fraudulent orders signed by providers, including **CHAPMAN**, shipped DME to beneficiaries, including to beneficiaries located in the Middle District of Louisiana, and subsequently submitted false and fraudulent claims to Medicare seeking reimbursement for the cost of the DME provided.

38. Upon being reimbursed by Medicare, the various DME providers paid kickbacks and bribes to Company 1, Company 2, and other companies, for identifying and soliciting beneficiaries' personally identifying information, and Company 3, Company 4, Company 5, and other companies for obtaining the fraudulent orders.

39. In exchange for the fraudulent orders authorizing medically unnecessary DME for beneficiaries, **CHAPMAN** received kickbacks and bribes from Company 3, Company 4, Company 5, and other companies, knowing that his orders for medically unnecessary DME would be used to support false and fraudulent claims to Medicare.

40. Between at least September 2016 continuing through August of 2019, **CHAPMAN** caused the submission of approximately $4,815,493.84 in false and fraudulent claims to Medicare for DME, specifically knee braces, that were ineligible for Medicare reimbursement because the DME was not medically necessary, procured through the payment of illegal kickbacks and bribes, and/or not actually supplied to the beneficiaries.

COUNT 1
Conspiracy to Commit Health Care Fraud
(18 U.S.C. § 1349)

The Conspiracy and Its Object

41. Paragraphs 1 through 24 of the Indictment are re-alleged and incorporated by reference as though fully set forth herein.

42. Beginning in at least September 2016, and continuing through August 2019, in the Middle District of Louisiana, and elsewhere, the defendant, **J. FOSTER CHAPMAN, D.O.**, conspired and agreed with others known and unknown to the Grand Jury, to commit certain offenses against the United States, that is, to knowingly and willfully execute, and attempt to 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 other health care benefit programs, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money owned by, and under the custody and control of, Medicare and other health care benefit programs, in connection with the delivery of and payment for health care benefits, items, and services, in violation of Title 18, United States Code, Section 1347.

Purpose of the Conspiracy

43. It was a purpose of the conspiracy for **CHAPMAN** and his co-conspirators to unlawfully enrich themselves, as described in paragraphs 25-27, and re-alleged and incorporated by reference as though fully set forth herein.

Manner and Means of the Conspiracy

44. In furtherance of the conspiracy and to accomplish its objects and purpose, the methods, manner, and means that were used are described in paragraphs 28 through 39, are re-alleged and incorporated by reference as thought fully set forth herein.

All in violation of Title 18, United States Code, Section 1349.

COUNTS 2-5
Health Care Fraud
(18 U.S.C. §§ 1347 and 2)

Scheme to Defraud

45. Paragraphs 1 through 40 of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

46. From in or around September 2016, and continuing through August of 2019, in the Middle District of Louisiana and elsewhere, the defendant, **J. FOSTER CHAPMAN, D.O.**, aided and abetted by others known and unknown to the Grand Jury, in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, a scheme or 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 other health care benefit programs, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money owned by, and under the custody and control of, Medicare and other health care benefit programs.

47. The scheme to defraud is more fully described in paragraphs 25 through 40 of the Indictment and is re-alleged and incorporated by reference as if fully set forth herein.

Execution of the Scheme to Defraud

48. In order to execute and attempt to execute the scheme to defraud and to obtain money and property, and to accomplish the objects of the scheme, the defendant, **J. FOSTER CHAPMAN, D.O.**, committed, caused others to commit, and aided and abetted others in committing the following acts within the Middle District of Louisiana, and elsewhere, that is, on or about the dates listed below, **CHAPMAN**: (a) signed fraudulent orders purportedly authorizing DME to be delivered to beneficiaries located in the Middle District of Louisiana, without conducting the required in-person examinations; (b) caused various DME providers to ship and deliver medically unnecessary DME to beneficiaries located in the Middle District of Louisiana; and (c) further caused various DME providers to submit false and fraudulent claims to Medicare, which claims indicated that DME had been prescribed to Medicare beneficiaries, when such orders for braces were ineligible for Medicare reimbursement because they were medically unnecessary, procured through the payment of illegal kickbacks and bribes, and/or not actually supplied to the beneficiaries:

Count	Bene-ficiary	Approx. Date of Call with Bene-ficiary	Approx. Date of Fraudulent Order	Approx. Date of Purported Shipment and Claim	HCPCS Code	Amount Billed	Amount Paid
2	H.B.	11/10/16	11/10/16	11/11/16	L1833 (Knee Brace)	$867.11	$424.88
3	G.B.	03/02/17	03/02/17	03/06/17	L1833 (Knee Brace)	$867.11	$427.85
4	A.A.	06/20/17	06/20/17	06/23/17	L1833 (Knee Brace)	$1,702.16	$427.85
5	R.L.	07/05/17	07/05/17	07/07/17	L1833 (Knee Brace)	$1,702.16	$427.85

Each of the above is a violation of Title 18, United States Code, Sections 1347 and 2.

FORFEITURE ALLEGATIONS

49. Upon conviction of any of the offenses set forth above, the defendant, **J. FOSTER CHAPMAN, D.O.**, shall forfeit to the United States pursuant to 18 U.S.C. § 982(a)(7), all property, real and personal, that constitutes or is derived, directly or indirectly, from gross proceeds of the violations, including but not limited to a sum of money equal to the amount of the gross proceeds of the offenses.

50. If any of the above-described forfeitable property, as a result of any act or omission of the defendant:

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

b. has been transferred or 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;

it is the intent of the United States, pursuant to 21 U.S.C. § 853(p) as incorporated by 18 U.S.C. § 982(b), to seek forfeiture of any other property of the defendant up to the value of the forfeitable property described above.

UNITED STATES OF AMERICA, by

BRANDON J. FREMIN
UNITED STATES ATTORNEY

KRISTEN L. CRAIG
ASSISTANT UNITED STATES ATTORNEY

JUSTIN M. WOODARD
TRIAL ATTORNEY
CRIMINAL DIVISION, FRAUD SECTION
UNITED STATES DEPARTMENT OF JUSTICE

A TRUE BILL

REDACTED
PER PRIVACY ACT

GRAND JURY FOREPERSON

9-18-2019
DATE

Criminal Cover Sheet — U.S. District Court

Place of Offense:

City: Baton Rouge

County/Parish: East Baton Rouge Parish

Agent: Bryan Young-HS-OIG

Matter to be sealed: ☐No X Yes

Related Case Information:

Superseding Indictment _____ Docket Number _____
Same Defendant _____ New Defendant X
Magistrate Case Number _____
Search Warrant Case No. _____
R 20/ R 40 from District of _____
Any Other Related Cases: _____

Defendant Information:

Defendant Name: J. Foster Chapman, D.O.

U.S. Attorney Information:

AUSA Kristen L. Craig — Bar # LBN 32565

Interpreter: ☐ No ☐ Yes **List language and/or dialect:** _____

Location Status:

Arrest Date _____

_____ Already in Federal Custody as of
_____ Already in State Custody
_____ On Pretrial Release

U.S.C. Citations:

Total # of Counts: 5

Index Key/Code	Description of Offense Charged	Count(s)	Petty/ Misdemeanor/ Felony
18:1349	Conspiracy to Commit Health Care Fraud	1	F
18:1347 & 2	Health Care Fraud	2-5	F

(May be continued on second sheet)

Date: 9/18/19 **Signature of AUSA:** Kristen Craig

District Court Case Number (To be filled in by deputy clerk): _____