UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF TENNESSEE
COLUMBIA DIVISION

UNITED STATES OF AMERICA	)	
	)	No. 1:20-00004
v.	)	
	)	18 U.S.C. § 371
VERNON R. SANDERS	)	

INFORMATION

THE UNITED STATES ATTORNEY CHARGES:

INTRODUCTION

At all times material to this Information:

1. The Medicare Program ("Medicare") was a federal healthcare program that provided benefits to individuals who were sixty-five years of age or older, or disabled. The benefits available under Medicare were governed by federal statutes and regulations. The United States Department of Health and Human Services ("HHS"), through its agency the Center for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare. Individuals who received benefits under Medicare were commonly referred to as Medicare "beneficiaries."

2. 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 in Title 42, United States Code, Section 1320a-7b.

3. Medicare programs covering different types of benefits were separated into different program "parts." "Part A" of the Medicare program covered health services provided by hospitals, skilled nursing facilities, hospices and home health agencies. "Part B" of the Medicare Program was a medical insurance program that covered, among other things, medical services provided by physicians, medical clinics, laboratories and other qualified health care providers,

such as office visits, minor surgical procedures, and laboratory testing, that were medically necessary and ordered by licensed medical doctors or other qualified health care providers. The Medicare Advantage Program, formerly known as "Part C" or "Medicare+Choice," is described in further detail below.

4. Physicians, clinics and other health care providers, including laboratories, 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.

5. A Medicare claim was required to contain certain important information, including: (a) the Medicare beneficiary's name and Health Insurance Claim Number ("HICN"); (b) a description of the health care benefit, item, or service that was provided or supplied to the beneficiary; (c) the billing codes for the benefit, item, or service; (d) the date upon which the benefit, item, or service was provided or supplied to the beneficiary; and (e) the name of the referring physician or other health care provider, as well as a unique identifying number, known either as the Unique Physician Identification Number ("UPIN") or National Provider Identifier ("NPI"). The claim form could be submitted in hard copy or electronically.

PART B COVERAGE AND REGULATIONS

6. CMS acted through fiscal agents called Medicare administrative contractors ("MACs"), which were statutory agents for CMS for Medicare Part B. The MACs were private entities that reviewed claims and made payments to providers for services rendered to Medicare beneficiaries. The MACs were responsible for processing Medicare claims arising within their assigned geographical area, including determining whether the claim was for a covered service.

7. Novitas Solutions Inc. ("Novitas") was the MAC for the consolidated Medicare jurisdictions that covered Louisiana, Mississippi, Oklahoma, Texas, and Pennsylvania. Palmetto GBA ("Palmetto") was the MAC for the consolidated Medicare jurisdictions that included Georgia, Alabama, Tennessee, South Carolina, North Carolina, Virginia, and West Virginia.

8. To receive Medicare reimbursement, providers had to make appropriate application to the MAC and executed a written provider agreement. The Medicare provider enrollment application, CMS Form 855B, was required to be signed by an authorized representative of the provider. CMS Form 855B contained a certification that stated:

> I agree to abide by the Medicare laws, regulations, and program instructions that apply to this provider. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations and program instructions (including, but not limited to, the federal anti-kickback statute and the Stark law), and on the provider's compliance with all applicable conditions of participation in Medicare.

9. CMS Form 855B contained additional certifications 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."

10. Payments under Medicare Part B were often made directly to the health care provider rather than to the patient or beneficiary. For this to occur, the beneficiary would assign the right of payment to the health care provider. Once such an assignment took place, the health care provider would assume the responsibility for submitting claims to, and receiving payments from, Medicare.

THE MEDICARE ADVANTAGE PROGRAM

11. The Medicare Advantage Program, formerly known as "Part C" or "Medicare+Choice," provided Medicare beneficiaries with the option to receive their Medicare

benefits through a wide variety of private managed care plans, including health maintenance organizations ("HMOs"), provider sponsored organizations ("PSOs"), preferred provider organizations ("PPOs"), and private fee-for-service plans ("PFFS"), rather than through the original Medicare program (Parts A and B).

12. Private health insurance companies offering Medicare Advantage plans were required to provide Medicare beneficiaries with the same services and supplies offered under Parts A and B of Medicare. To be eligible to enroll in a Medicare Advantage plan, a person had to have been entitled to benefits under Part A and Part B of the Medicare Program.

13. A number of companies, including UnitedHealth Group, Inc. ("UnitedHealth"), Humana Inc. ("Humana"), WellCare Health Plans, Inc. ("WellCare") and CVS Health Corporation ("CVS Health"), along with their related subsidiaries and affiliates, contracted with CMS to provide managed care to Medicare Advantage beneficiaries through various plans.

14. Medicare Advantage plans, including UnitedHealth, Humana, WellCare and CVS Health were "health care benefit programs," as defined by Title 18, United States Code, Section 24(b), and "Federal health care program[s]," as defined by Title 42, United States Code, Section 1320a-7b(f).

15. These companies, through their respective Medicare Advantage programs, often made payments directly to physicians, medical clinics, or other health care providers, rather than to the Medicare Advantage beneficiary that received the health care benefits, items, and services. This occurred when the provider accepted assignment of the right to payment from the beneficiary.

16. To obtain payment for services or treatment provided to a beneficiary enrolled in a Medicare Advantage plan, physicians, medical clinics, and other health care providers had to submit itemized claim forms to the beneficiary's Medicare Advantage plan. The claim forms were

typically submitted electronically via the internet. The claim form required certain important information, including the information described above in Paragraph 5.

17. When a provider submitted a claim form to a Medicare Advantage program, the provider party certified that the contents of the form were true, correct, complete, and that the form was prepared in compliance with the laws and regulations governing the Medicare program. The submitting party also certified that the services being billed were medically necessary and were in fact provided as billed.

18. The private health insurance companies offering Medicare Advantage plans were paid a fixed rate per beneficiary per month by the Medicare program, regardless of the actual number or type of services the beneficiary received. These payments by Medicare to the insurance companies were known as "capitation" payments. Thus, every month, CMS paid the health insurance companies a pre-determined amount for each beneficiary who was enrolled in a Medicare Advantage plan, regardless of whether or not the beneficiary utilized the plan's services that month. CMS determined the per-patient capitation amount using actuarial tables, based on a variety of factors, including the beneficiary's age, sex, severity of illness, and county of residence. CMS adjusted the capitation rates annually, taking into account each patient's previous illness diagnoses and treatments. Beneficiaries with more illnesses or more serious conditions would rate a higher capitation payment than healthier beneficiaries.

CANCER GENOMIC TESTS

19. 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.

20. 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)(l)(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)(l). 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.*

21. 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.*

22. 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.

TELEMEDICINE

23. Telemedicine provided a means of connecting patients to doctors by using telecommunications technology, such as the internet or telephone, to interact with a patient.

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

25. Medicare Part B covered expenses for specified telehealth services if certain requirements were met. These requirements included that (a) the beneficiary was located in a rural or health professional shortage area; (b) services were delivered via an interactive audio and video telecommunications system; and (c) the beneficiary was a practitioner's office or a specified medical facility - not at a beneficiary's home - during the telehealth consultation with a remote practitioner.

THE DEFENDANT AND RELATED INDIVIDUALS

26. Defendant **VERNON R. SANDERS** was a resident of Meridian, Mississippi, and was an owner of FASTSCRIPTS, LLC.

27. Individual 1 was a resident of Loretto, Lawrence County, Tennessee and a medical doctor licensed in the states of Tennessee and Mississippi.

28. Individual 2 was a resident of Gwinnett County, Georgia, and was the owner of several marketing companies.

29. Laboratory 1 was a corporation organized under the laws of Florida and later merged with a corporation organized under the laws of Georgia, and was a laboratory that purportedly provided CGx testing to Medicare beneficiaries.

COUNT ONE

(Conspiracy to Solicit and Receive Health Care Kickbacks, 18 U.S.C. § 371)

30. Paragraphs 1 through 29 are re-alleged and incorporated by reference as though fully set forth herein.

31. From on or around June 2016 and continuing through on or around January 2020, in the Middle District of Tennessee and elsewhere, **VERNON R. SANDERS** did willfully and knowingly combine, conspire, confederate, and agree with Individual 1, Individual 2, and others known and unknown to the United States Attorney:

a. to defraud the United States by impairing, impeding, obstructing, and defeating through deceitful and dishonest means, the lawful government functions of the United States Department of Health and Human Services in its administration and oversight of the Medicare program, in violation of Title 18, United States Code, Section 371, and to commit certain offenses against the United States, that is:

b. to violate Title 42, United States Code, Section 1320a-7b(b)(1)(A)&(B), by knowingly and willfully soliciting and receiving remuneration, including kickbacks, bribes, and rebates, directly and indirectly, overtly and covertly, in cash and in kind, in return for referring an individual to a person for the furnishing and arranging for the furnishing of any item or service for which payment may be made in whole and in part under a Federal health care program, that is, Medicare and in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service and item for which payment may be made in whole or in part under a Federal health care program, that is, Medicare; and

c. to violate Title 42, United States Code, Section 1320a-7b(b)(2)(A)&(B), by knowingly and willfully offering and paying remuneration, including kickbacks, bribes, and rebates, directly and indirectly, overtly and covertly, in cash and in kind to any person to induce such person to refer an individual to a person for the furnishing and arranging for the furnishing of any item or service for which payment may be made in whole or in part a Federal health care program, that is, Medicare, and to purchase, lease, order, and arrange for and recommend purchasing, leasing, and ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, that is, Medicare.

PURPOSE OF THE CONSPIRACY

32. It was the purpose of the conspiracy for **VERNON R. SANDERS** and his co-conspirators, and others known and unknown to the United States Attorney, to unlawfully enrich themselves by, among other things: (a) soliciting and receiving kickbacks and bribes in return for recruiting and referring Medicare beneficiaries for CGx testing to Individual 2, who then referred the patients to laboratories, including Laboratory 1; (b) soliciting and receiving kickbacks and bribes in return for recruiting, recommending and referring Medicare beneficiaries for CGx testing directly to laboratories, including Laboratory 1; (c) offering and paying kickbacks and bribes to doctors, including Individual 1, in return for Individual 1 signing doctors' orders for CGx; (d) offering and paying kickbacks and bribes to marketers, in return for marketers recruiting, recommending and referring Medicare beneficiaries to obtain genetic material for CGx testing kits and to sign medical documentation; (e) submitting and causing the submission of claims to Medicare and Medicare Advantage plans for CGx tests that laboratories purported to provide to

those Medicare beneficiaries, including Laboratory 1; (f) concealing the kickbacks and bribes; and (g) diverting proceeds for their personal use and benefit, the use and benefit of others and to further the conspiracy.

MANNER AND MEANS

The manner and means by which **VERNON R. SANDERS** and his co-conspirators sought to accomplish the purpose of the conspiracy included, among other things, the following:

33. **VERNON R. SANDERS,** on his own and through Individual 2, solicited and received kickbacks and bribes from laboratories, including Laboratory 1, in exchange for CGx testing kits and doctors' orders for CGx tests, including orders signed by Individual 1, and other Medicare-required documents that would be used to support claims to Medicare and Medicare Advantage plans for those tests from the laboratories.

34. **VERNON R. SANDERS**, on his own and through Individual 2, entered into sham contracts with laboratories, including Laboratory 1, that disguised kickbacks and bribes as payments from the laboratories for marketing services.

35. Individual 2 paid **VERNON R. SANDERS** to recruit Medicare beneficiaries and induce them to accept CGx tests regardless of the fact that these tests are not routinely covered by Medicare and were not medically necessary for these patients.

36. **VERNON R. SANDERS**, through his company FASTSCRIPTS, LLC, paid marketers to directly recruit Medicare beneficiaries to provide samples of their genetic material to the marketer in the form of CGx test kits and to sign documentation provided by the Marketer.

37. **VERNON R. SANDERS,** himself and through others, used the recruited Medicare beneficiary information to generate CGx orders.

38. **VERNON R. SANDERS** obtained signed doctors' orders for CGx tests for the recruited Medicare beneficiaries by paying physicians and telemedicine companies kickbacks and bribes, including to Individual 1.

39. **VERNON R. SANDERS** paid doctors for the signed CGx orders, including Individual 1, by checks that disguised the kickbacks and bribes as payments for "leads" and "consults."

40. Individual 1 signed CGx orders provided by **VERNON R. SANDERS**, from Individual 1's home in Loretto, Tennessee.

41. Individual 1 was not treating the beneficiaries for cancer or symptoms of cancer, did not use the test results in the treatment of the beneficiaries, and did not conduct an actual telemedicine visit.

42. **VERNON R. SANDERS** provided the CGx test kits and the signed CGx orders, including those signed by Individual 1, directly to laboratories, including Laboratory 1, or through Individual 2, who sent them to laboratories.

43. The payments for the CGx test kits and CGx orders were described by **VERNON R. SANDERS** and his co-conspirators as "leads" or "consults," when they were, in fact, kickbacks and bribes paid for orders that were billed to and paid by Medicare.

44. **VERNON R. SANDERS** and others caused laboratories, including Laboratory 1, to submit claims to Medicare and Medicare Advantage plans for CGx laboratory testing.

45. As a result of these claims, Medicare and Medicare Advantage plans made payments to laboratories, including Laboratory 1.

OVERT ACTS

In furtherance of the conspiracy, and to accomplish its object and purpose, at least one coconspirator committed and caused to be committed, in the Middle District of Tennessee and elsewhere, at least one of the following overt acts, among others:

A. On or about January 16, 2018, Laboratory 1 submitted a claim to Medicare of approximately $8,000 for a CGx testing claim for Patient 1, for an order signed by Individual 1.

B. On or about February 13, 2018, **VERNON R. SANDERS** sent a text message to Individual 2 stating, in part:

40 leads @800.0=32,000. Comp
14 leads @600.0=8400.0 colorectal
14 leads @ 400=5600 bra

68 leads total@ $46,000.0

C. On or about February 15, 2018, **VERNON R. SANDERS** offered and paid marketer E.H. approximately $6,200 via check. The memorandum line of the check stated "31 kits 1099."

D. On or about February 15, 2018, **VERNON R. SANDERS** offered and paid Individual 1 approximately $3,780, via check. The memorandum line of the check stated "63 leads 1099."

E. On or about February 16, 2018, **VERNON R. SANDERS** solicited and received a wire transfer from a company owned by Individual 2, in the amount of approximately $46,000.

F. On or about January 17, 2019, Individual 1 sent an email to **VERNON R. SANDERS** that stated: "I don't want to complete any more kits until I receive what is owed me."

All in violation of Title 18, United States Code, Section 371.

FORFEITURE ALLEGATION

46. The allegations of this information are re-alleged and incorporated by reference as though fully set forth herein for purposes of alleging forfeiture to the United States of certain property in which the defendant has an interest.

47. Upon conviction of a criminal conspiracy to commit a violation of Title 42, United States Code, Section 1320a-7b, as alleged in this Information, **VERNON R. SANDERS** shall forfeit to the United States any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense, pursuant to Title 18, United States Code, Section 982(a)(7).

48. The property subject to forfeiture includes, but is not limited to, the sum of money equal in value to the gross proceeds traceable to the commission of the violation alleged in this Information, which the United States will seek as a forfeiture money judgment as part of each defendant's sentence.

49. If any of the above-described forfeitable property, as a result of any act or omission of **VERNON R. SANDERS**:

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 that cannot be divided without difficulty,

the United States shall be entitled to forfeiture of substitute property, and it is the intent of the

United States, pursuant to Title 21, United States Code, Section 853(p) to seek forfeiture of any other property of **VERNON R. SANDERS**.

DONALD Q. COCHRAN
UNITED STATES ATTORNEY

SARAH K. BOGNI
ASSISTANT UNITED STATES ATTORNEY