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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

v.

JOSEPH HAGEN,

Defendant.
_____/

Case: 2:22-cr-20376
Judge: Goldsmith, Mark A.
MJ: Patti, Anthony P.
Filed: 07-19-2022 At 03:24 PM
IND USA V JOSEPH HAGEN (SS)

VIO: 18 U.S.C. § 1347
18 U.S.C. § 2
18 U.S.C. § 982

INDICTMENT

THE GRAND JURY CHARGES:

GENERAL ALLEGATIONS

At all times relevant to this Indictment:

The Medicare Program

1. The Medicare program ("Medicare") was a federal health care program providing benefits to persons who were 65 years of age or older or disabled. Medicare was administered by the Centers for Medicare and Medicaid Services ("CMS"), a federal agency under the United States Department of Health and Human Services ("HHS"). Individuals who received benefits under Medicare were 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 by Title 42, United States Code, Section 1320a-7b(f).

3. Medicare was divided into four parts and covered specific benefits, items, and services: hospital insurance (Part A), medical insurance (Part B), Medicare Advantage (Part C), and prescription drug benefits (Part D).

4. Specifically, Medicare Part B covered medically necessary physician office services and outpatient care, including the ordering of durable medical equipment, prosthetics, orthotics, and supplies (collectively, "DME") that were ordered by licensed medical doctors or other qualified health care providers.

5. 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.

6. To receive Medicare reimbursement, providers had to fill out an application and execute a written provider agreement, known as CMS Form 855. The application contained certifications that the provider agreed to abide by Medicare laws and regulations, and that the provider "[would] not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and

[would] not submit claims with deliberate ignorance or reckless disregard of their truth or falsity." Medicare providers were given access to Medicare manuals and service bulletins describing procedures, rules, and regulations.

7. CMS contracted with various companies to receive, adjudicate, process, and pay Part B claims, including claims for DME. Wisconsin Physicians Service was the CMS contracted carrier for Medicare Part B in the state of Michigan. AdvanceMed (now known as "CoventBridge Group") was the Zone Program Integrity Contractor for the state of Michigan, and as such, it was the Medicare contractor charged with investigating fraud, waste, and abuse.

Durable Medical Equipment

8. 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 required minimal self-adjustment for appropriate use and did not require expertise in trimming, bending, molding, assembling, or customizing to fit the individual.

9. A claim for DME submitted to Medicare qualified for reimbursement only if it was medically necessary for the treatment or diagnosis of the beneficiary's illness or injury and prescribed by a licensed physician. 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. To be reimbursed from Medicare for DME, the claim had to be reasonable, medically necessary, documented, and actually provided as represented to Medicare.

10. Medicare claims were required to be properly documented in accordance with Medicare rules and regulations. For certain DME products, Medicare promulgated additional requirements that a DME order was required to meet for an order to be considered "reasonable and necessary." For example, for OTS knee braces billed to Medicare under the Healthcare Common Procedure Coding System ("HCPCS") Code L1851, an order would be deemed "not reasonable and necessary," and reimbursement would be denied unless the ordering/referring physician documented the beneficiary's knee instability using an objective description of joint laxity determined through an examination of the beneficiary.

Telemedicine

11. Telemedicine provided a means of connecting patients to doctors and other health care providers by using telecommunications technology to interact with a patient.

12. Telemedicine companies provided telemedicine services to individuals by hiring doctors and other health care providers. In order to generate revenue,

telemedicine companies typically either billed insurance or received payment from patients who utilized the services of the telemedicine company.

13. Medicare Part B 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.

14. In or around March 2020, in response to the COVID-19 pandemic, some of the requirements for telemedicine services were amended temporarily to, among other things, cover telehealth services for certain office and hospital visits, even if the beneficiary was not located in a rural area or a health professional shortage area, and even if the telehealth services were furnished to beneficiaries in their home.

The Defendant

15. Defendant JOSEPH HAGEN, a resident of Dearborn, Michigan, was a physician licensed to practice in Michigan. JOSEPH HAGEN was a Medicare provider and was required to abide by all Medicare rules and regulations. JOSEPH HAGEN worked as an independent contractor for purported telemedicine staffing

companies such as Company 1, which would connect medical practitioners with patients, as well as purported telemedicine companies such as Company 2, described below.

Related Individuals and Entities

16. Company 1, a company known to the Grand Jury, was a Massachusetts company that operated as a purported telemedicine staffing company that did business throughout the United States.

17. Company 2, a company known to the Grand Jury, was a Florida company that operated as a purported telemedicine company that did business throughout the United States.

18. E.L. was a beneficiary residing in the Eastern District of Michigan.

19. D.R. was a beneficiary residing in the Eastern District of Michigan.

20. A.M. was a beneficiary residing in the Eastern District of Michigan.

21. J.B. was a beneficiary residing in the Eastern District of Michigan.

COUNTS 1 - 11
18 U.S.C. §§ 1347 and 2
(Health Care Fraud)

22. Paragraphs 1 through 21 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

23. From in or around April 2020, and continuing through in or around March 2021, the exact dates being unknown to the Grand Jury, in Wayne County, in the Eastern District of Michigan, and elsewhere, the defendant, JOSEPH HAGEN, 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 and artifice to defraud Medicare and other health care benefit programs affecting commerce, as defined in Title 18, United States Code, Section 24(b), 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, and services.

Purpose of the Scheme and Artifice

24. It was a purpose of the scheme and artifice for JOSEPH HAGEN and his accomplices to unlawfully enrich themselves by: (a) submitting and causing the submission of false and fraudulent claims to Medicare that were (i) medically unnecessary, (ii) not eligible for Medicare reimbursement, and (iii) not provided as represented; (b) concealing the submission of false and fraudulent claims and the receipt and transfer of the proceeds from the fraud; and (c) diverting proceeds of the fraud for their personal use and benefit.

The Scheme and Artifice

25. On or about January 15, 2009, JOSEPH HAGEN certified to Medicare that he would comply with all Medicare rules and regulations. For all times during the charged period, JOSEPH HAGEN 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.

26. Thereafter, JOSEPH HAGEN devised and engaged in a scheme to submit false and fraudulent claims to Medicare for: (a) DME that was not medically necessary; and (b) DME that was not eligible for reimbursement from Medicare.

27. JOSEPH HAGEN agreed with others at Company 1 and Company 2 to sign brace orders for Medicare beneficiaries in exchange for approximately $20 per order reviewed.

28. JOSEPH HAGEN received pre-filled unsigned prescriptions for DME for Medicare beneficiaries, from accomplices working on behalf of Company 1 and Company 2, for him to electronically sign.

29. JOSEPH HAGEN ordered braces that were medically unnecessary, for Medicare beneficiaries with whom he lacked a pre-existing medical practitioner-patient relationship, without a physical examination, and/or without communicating substantively with the Medicare beneficiary.

30. JOSEPH HAGEN and others falsified, fabricated, altered, and caused the falsification, fabrication, and alteration of patient files, brace orders, and other records, all to support claims to Medicare for braces that were medically unnecessary, ineligible for Medicare reimbursement, and not provided as represented.

31. Specifically, JOSEPH HAGEN: (a) falsely stated that he determined, through his assessment of the Medicare beneficiary, that a particular course of treatment, including the prescription of braces, was appropriate and medically necessary; (b) falsely attested that the he was treating the Medicare beneficiary; (c) falsely represented that certain diagnostic tests had been performed prior to ordering braces; and (d) concealed the fact that he never saw the beneficiaries face-to-face, and that he did not have telephone conversations with most of the beneficiaries.

32. JOSEPH HAGEN submitted orders for DME on behalf of Medicare beneficiaries residing in the Eastern District of Michigan, and elsewhere, which caused DME providers to ship medically unnecessary DME to beneficiaries, including beneficiaries residing in the Eastern District of Michigan, and to submit claims to Medicare for reimbursement.

33. From in or around April 2020, through in or around March 2021, JOSEPH HAGEN and others submitted and caused the submission of more than $1,900,000 in false and fraudulent claims to Medicare for DME that was ineligible

for Medicare reimbursement because the DME was not medically necessary, not eligible for reimbursement, and not provided as represented. Medicare paid more than $1,000,000 on these claims.

Acts in Execution of the Scheme and Artifice

34. On or about the dates specified below, in Wayne County, in the Eastern District of Michigan, and elsewhere, the defendant, JOSEPH HAGEN, aided and abetted by, and aiding and abetting, others known and unknown to the Grand Jury, submitted and caused to be submitted the following false and fraudulent claims to Medicare for DME that was, among other things, not legitimately prescribed, not needed, and not used, and in execution of the scheme as described in paragraphs 25 to 33, with each execution set forth below forming a separate count:

Count	Medicare Beneficiary	Approx. Date of Claim	Claim Number	Description of Devices Billed; HCPCS Code	Approx. Amount Billed
1	E.L.	5/05/2020	20126838599000	Right and left wrist braces (L3916); Right and left knee braces (L1851); Suspension sleeve (L2397)	$3,575.00
2	E.L.	5/05/2020	20126838600000	Suspension sleeve (L2397)	$125.00
3	D.R.	6/12/2020	20164805545000	Right and left knee braces (L1851)	$2,316.28
4	A.M.	5/06/2020	20127832822000	Lumbar-sacral orthosis (L0648)	$1,407.08
5	A.M.	5/06/2020	20127832823000	Left knee brace and suspension sleeve (L1851 and L2397)	$1,371.06

Count	Medicare Beneficiary	Approx. Date of Claim	Claim Number	Description of Devices Billed; HCPCS Code	Approx. Amount Billed
6	A.M.	5/06/2020	20127832824000	Right ankle brace and heel stabilizer (L1906 and L3170)	$267.03
7	A.M.	5/07/2020	20128831623000	Right knee brace and suspension sleeve (L1851 and L2397)	$1,371.06
8	J.B.	7/01/2020	20183829914000	Right and left wrist braces (L3916)	$1,314.56
9	J.B.	7/01/2020	2018382991500	Lumbar-sacral orthosis (L0650)	$1,480.58
10	J.B.	7/02/2020	20184834586000	Right knee brace and suspension sleeve (L1851 and L2397)	$1,371.06
11	J.B.	7/02/2020	20184834588000	Left knee brace and suspension sleeve (L1851 and L2397)	$1,371.06

Each in violation of Title 18, United States Code, Sections 1347 and 2.

FORFEITURE ALLEGATIONS
Criminal Forfeiture
(18 U.S.C. § 982(a)(7))

35. The allegations contained in this Indictment are incorporated by reference as if set forth fully herein for the purpose of alleging forfeiture pursuant to the provisions of Title 18, United States Code, Section 982.

36. Upon conviction of the violations alleged in Counts 1 through 11 as set forth in this Indictment, the defendant, JOSEPH HAGEN, 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).

37. Substitute Assets: If the property described above as being subject to forfeiture, 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 that cannot be subdivided without difficulty;

it is the intent of the United States, pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b), to seek to forfeit any other property of the defendant, JOSEPH HAGEN, up to the value of the forfeitable property described above.

38. Money Judgment: The government shall also seek a forfeiture money judgment from the defendant for a sum of money representing the total amount of

property subject to forfeiture as a result of defendant's violations of 18 U.S.C. § 1347, as alleged in this Indictment.

THIS IS A TRUE BILL.

s/ Grand Jury Foreperson
GRAND JURY FOREPERSON

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