UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

v.

FAWN MUNRO,

Defendant.
_____/

Case: 1:22-cr-20375
Assigned To : Ludington, Thomas L.
Referral Judge: Morris, Patricia T.
Filed: 7/19/2022
IND USA V MUNRO (LH)

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 ("ZPIC") 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 Procedures 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.

The Defendant

14. Defendant FAWN MUNRO, a resident of Alpena, Michigan, was a registered nurse licensed to practice in Michigan. FAWN MUNRO was a Medicare provider and was required to abide by all Medicare rules and regulations. FAWN MUNRO worked as an independent contractor for purported telemedicine staffing companies, including Company 1, described below.

Related Individuals and Entities

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

16. 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.

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

18. W.A. was a beneficiary residing in the Eastern District of Michigan.

19. K.B. was a beneficiary residing in the Eastern District of Michigan.

20. K.E. was a beneficiary residing in the Eastern District of Michigan.

COUNTS 1-8
18 U.S.C. §§ 1347 and 2
(Health Care Fraud)

21. Paragraphs 1 through 20 of the General Allegations section of this Indictment are re-alleged and incorporated by reference as though fully set forth herein.

22. From in or around July 2018, and continuing through in or around April 2019, the exact dates being unknown to the Grand Jury, in Alpena County, in the Eastern District of Michigan, and elsewhere, the defendant, FAWN MUNRO, 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, a health care benefit program 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

23. It was a purpose of the scheme and artifice for FAWN MUNRO and her 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

24. On or about August 30, 2011; September 8, 2015; and October 30, 2015, FAWN MUNRO certified to Medicare that she would comply with all Medicare rules and regulations. For all times during the charged period, FAWN MUNRO was a Medicare provider and was required to abide by all Medicare rules and regulations and federal laws, including that she would not knowingly present or cause to be presented a false and fraudulent claim for payment by Medicare.

25. Thereafter, FAWN MUNRO 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.

26. FAWN MUNRO agreed with others at Company 1 to sign brace orders for Medicare beneficiaries in exchange for approximately $15 per order reviewed.

27. FAWN MUNRO received pre-filled unsigned prescriptions for DME for Medicare beneficiaries, from accomplices working on behalf of Company 1, for her to electronically sign.

28. FAWN MUNRO ordered braces that were medically unnecessary, for Medicare beneficiaries with whom she lacked a pre-existing medical practitioner-patient relationship, without a physical examination, and without communicating with the Medicare beneficiary.

29. FAWN MUNRO 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.

30. Specifically, FAWN MUNRO: (a) falsely stated that she determined, through her 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 she was treating the Medicare beneficiary; (c) falsely represented that she had performed certain diagnostic tests prior to ordering braces; and (d) concealed the fact that she never saw the beneficiaries face-to-face, and never had any telephone conversations with most of the beneficiaries.

31. FAWN MUNRO 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.

32. From in or around July 2018, through in or around April 2019, FAWN MUNRO and others submitted and caused the submission of more than $3.3 million 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 $1.8 million on these claims.

Acts in Execution of the Scheme and Artifice

33. On or about the date specified below, in Alpena County, in the Eastern District of Michigan, and elsewhere, the defendant, FAWN MUNRO, 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 claim 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 21 to 32, 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	J.J.	10/12/2018	118285804647 000	Right and left ankle braces (L1971)	$904.82
2	W.A.	12/21/2018	118355805877 000	Lumbar-sacral orthosis (L0650)	$1,610.54
3	W.A.	12/21/2018	118355805879 000	Left knee orthosis (L1833); Left addition to lower extremity orthosis, suspension sleeve (L2397)	$1,034.59
4	K.B.	1/09/2019	119009890373 9000	Lumbar-sacral orthosis (L0650)	$1,703.13
5	K.B.	1/09/2019	119009803741 000	Left knee orthosis (L1833); Left addition to lower extremity orthosis, suspension sleeve (L2397)	$1,075.73
6	K.B.	1/09/2019	119009803742 000	Left shoulder elbow wrist hand orthosis (L3960)	$934.74
7	K.B.	1/09/2019	119009803744 000	Right wrist brace (L3916)	$602.81
8	K.E.	8/02/2019	119214816324 000	Right and left ankle foot orthosis (L1971); Lumbar-sacral orthosis (L0650); Right and left knee orthosis (L1851); Right and left addition to lower extremity	$4,800.00

Count	Medicare Beneficiary	Approx. Date of Claim	Claim Number	Description of Devices Billed; HCPCS Code	Approx. Amount Billed
				orthosis, suspension sleeve (L2397)	

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

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

34. 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.

35. Upon conviction of the violation alleged in Counts 1-8 as set forth in this Indictment, the defendant, FAWN MUNRO, shall forfeit to the United States any property, real or personal, that constitutes or is derive, 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, FAWN MUNRO, 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 proceeds obtained as a result of defendant's violation of 18 U.S.C. § 1347, as alleged in this Indictment.

THIS IS A TRUE BILL.

s/ Grand Jury Foreperson
GRAND JURY FOREPERSON

DAWN N. ISON
UNITED STATES ATTORNEY

LORINDA I. LARYEA
Acting Chief
Criminal Division, Fraud Section
U.S. Department of Justice

DUSTIN M. DAVIS
Acting Chief, Health Care Fraud Unit
Criminal Division, Fraud Section
U.S. Department of Justice

REGINA MCCULLOUGH
Chief, Health Care Fraud Unit
United States Attorney's Office
Eastern District of Michigan

s/ Kathleen Cooperstein
KATHLEEN C. COOPERSTEIN
Trial Attorney
Criminal Division, Fraud Section
U.S. Department of Justice
211 W. Fort Street, Suite 2001
Detroit, MI 48226
Phone: (202) 957-2958
Email: kathleen.cooperstein@usdoj.gov

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