2022R00263/DCH/ES

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA	:	Hon. Kevin McNulty
	:	
v.	:	Criminal No. 22-487
	:	
JAGDISH IYER	:	18 U.S.C. § 1349

I N F O R M A T I O N

The defendant having waived in open court prosecution by Indictment, the United States Attorney for the District of New Jersey charges:

1. Unless otherwise indicated, at all times relevant to this Information:

a. Defendant JAGDISH IYER ("Defendant IYER") was a resident of New Jersey. Defendant IYER owned, operated, and had a financial interest in various entities located in New Jersey (the "IYER Supply Companies") through which Defendant IYER obtained doctors' orders for orthotic braces (also called "durable medical equipment" or "DME") (hereinafter referred to as "DME Orders").

b. Individual-1 was a resident of India who owned, operated, and had a financial and controlling interest in "Company-1," a patient recruiting company located in India and elsewhere. Company-1 primarily supplied DME

Orders, including orders for knee, ankle, back, wrist, and shoulder braces for Medicare beneficiaries.

c. Individual-2 was a resident of Canada, who owned, operated, and had a financial interest in the "Telemedicine Company," a telemedicine company located in Florida.

The Medicare Program

d. Medicare was a federally-funded program established by the Social Security Act of 1965 (codified as amended in various sections of Title 42, United States Code) to provide medical insurance benefits for individuals age 65 and older and certain disabled individuals who qualify under the Social Security Act. Individuals who received benefits under Medicare were referred to as "Medicare beneficiaries."

e. Medicare was administered by the Centers for Medicare and Medicaid Services, a federal agency under the United States Department of Health and Human Services.

f. Medicare was divided into four parts that helped cover specific services: Part A (hospital insurance), Part B (medical insurance), Part C (Medicare Advantage), and Part D (prescription drug coverage).

g. Medicare Part B covered non-institutional care that included physician services and supplies, such as DME, that were needed to diagnose or treat medical conditions and that met accepted standards of medical practice.

h. Medicare was a "health care benefit program," as defined by 18 U.S.C. § 24(b), and a "Federal health care program," as defined by 42 U.S.C. § 1320a-7b(f), that affected commerce.

i. In order for a DME supplier to bill Medicare Part B, that supplier had to enroll with Medicare as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies ("DMEPOS") supplier by completing a Form CMS-855S.

j. As provided in the Form CMS-855S, to enroll as a DMEPOS supplier, every DMEPOS supplier had to meet certain standards to obtain and retain billing privileges with Medicare, such as, but not limited to the following: (1) provide complete and accurate information on the Form CMS-855S, with any changes to the information on the form reported within 30 days; (2) disclose persons and organizations with ownership interests or managing control; (3) abide by applicable Medicare laws, regulations, and program instructions, such as, but not limited to, the Federal Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)); (4) acknowledge that the payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions; and (5) refrain from knowingly presenting or causing to be presented a false or fraudulent claim for payment by Medicare and submitting claims with deliberate ignorance or reckless disregard of their truth or falsity.

k. Medicare-authorized suppliers of health care services, such as DMEPOS suppliers, could submit claims to Medicare only for reasonable and

medically necessary services. Medicare would not reimburse claims for items or services that it knew were procured through kickbacks or bribes or that were medically unnecessary or not provided as represented. By implementing these restrictions, Medicare aimed to preserve its resources, which were largely funded by United States taxpayers, for elderly and other qualifying beneficiaries who had a genuine need for medical services.

The Conspiracy

2. From in or around October 2019 through in or around June 2021, in the District of New Jersey and elsewhere, Defendant

JAGDISH IYER

did knowingly and intentionally conspire and agree with others to knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud a health care benefit program, as defined by 18 U.S.C. § 24(b), that is Medicare, and to obtain, by means of false and fraudulent pretenses, representations, and promises, any of the money owned by, and under the custody and control of said health care benefit program, in connection with the delivery of or payment for health care benefits, items, and services, contrary to Title 18, United States Code, Section 1347.

Goal of the Conspiracy

3. The goal of the conspiracy was for Defendant IYER and his co-conspirators to unlawfully enrich themselves and others by causing the submission of false and fraudulent claims to Medicare.

Manner and Means of the Conspiracy

4. It was a part of the conspiracy that:

a. In or around October 2019, Defendant IYER, Individual-1, and others agreed that Defendant IYER would purchase DME Orders from Company-1 and others, and that Defendant IYER would pay approximately $300 for each DME Order for a back brace, $200 for each DME Order for a knee or shoulder brace, and $100 for each DME Order for a wrist or ankle brace. Shortly thereafter, Defendant IYER began to purchase DME Orders from Company-1 and others in exchange for kickbacks. The IYER Supply Companies then billed Medicare for the DME Orders that they had obtained in exchange for kickbacks.

b. Company-1 and others procured DME Orders through their access to telemarking and telemedicine companies. To generate DME Orders, Individual-1 and others first identified qualified beneficiaries located in New Jersey and elsewhere through the use of marketing call centers under their direction. Once beneficiaries were identified by the marketers, the IYER Supply Companies used telemedicine companies to secure DME Orders, despite the prescriptions being medically unjustified for the beneficiaries.

c. The DME Orders procured by Company-1 and others were also the product of kickbacks. Specifically, Individual-1 and co-conspirators entered kickback arrangements with telemedicine companies to use their doctors and nurses to approve DME Orders. Defendant IYER agreed that Individual-1 would pay the telemedicine companies kickbacks for each DME Order that the telemedicine companies provided. The telemedicine companies, in turn,

arranged to the pay health care providers under their control per "consultation" that resulted in a DME Order.

d. For example, Company-1 entered a kickback arrangement with the Telemedicine Company, which, among other things, hired doctors and nurses to approve DME Orders that would be reimbursed by Medicare. Defendant IYER agreed that Individual-1 would pay the Telemedicine Company approximately $100 for each DME Order that Individual-2 provided to Individual-1. Individual-1, in turn, arranged to pay health care providers under his control per "consultation" that resulted in a DME Order.

e. To conceal and disguise the scheme, Defendant IYER opened the IYER Supply Companies in the names of nominee owners.

f. To further conceal and disguise the scheme, Defendant IYER and others entered sham contracts and created false and fraudulent invoices that labeled payments for the purchasing of DME Orders as "marketing hours" or "business process outsourcing" expenditures.

g. After obtaining DME Orders, Company-1 transmitted the orders to the IYER Supply Companies, which billed Medicare.

h. In this manner, Defendant IYER submitted and caused the submission of claims to Medicare for DME that were (i) medically unnecessary; (ii) obtained through the payment of kickbacks and bribes and therefore not eligible for Medicare reimbursement; and (iii) not provided as represented.

i. As a result of the scheme, the IYER Supply Companies billed Medicare approximately $11.3 million, and Medicare paid the IYER Supply

Companies at least approximately $5.7 million based on false and fraudulent claims for DME.

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

FORFEITURE ALLEGATION

1. Upon conviction of the offense alleged in the Information, Defendant IYER shall forfeit to the United States, pursuant to 18 U.S.C. § 982(a)(7), all property, real or personal, that constitutes or is derived, directly and indirectly, from gross proceeds traceable to the commission of the offense (as defined in 18 U.S.C. § 24) alleged in this Information, including, but not limited to, a sum of money equal to $5.7 million.

SUBSTITUTE ASSETS PROVISION

2. 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 person;

(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 subdivided without difficulty;

the United States shall be entitled to forfeiture of substitute property, pursuant to 21 U.S.C. § 853(p), as incorporated by 18 U.S.C. § 982(b).

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