

UNITED STATES DISTRICT COURT  
FOR THE  
DISTRICT OF VERMONT

U.S. DISTRICT COURT  
DISTRICT OF VERMONT  
FILED

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UNITED STATES OF AMERICA

v.

DONALD JANI,

Defendant.

Criminal No. 2:25-cr-55-1

INDICTMENT

The Grand Jury charges:

GENERAL ALLEGATIONS

At times material to this Indictment:

Medicare Program

1. The Medicare Program ("Medicare") was a federally funded program that provided free or below-cost health care benefits to certain individuals, primarily the elderly, blind, and 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 Centers for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare.

2. Medicare was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b).

3. Individuals who received benefits under Medicare were commonly referred to as Medicare "beneficiaries." Each Medicare beneficiary was given a unique Medicare identification number.

4. Medicare covered different types of benefits, which were separated into different program “parts.” Medicare Part A covered health services provided by hospitals, skilled nursing facilities, hospices, and home health agencies. Medicare Part B covered, among other things, medical services provided by physicians, medical clinics, and other qualified health care providers, such as office visits, minor surgical procedures, and durable medical equipment (“DME”), that were medically necessary and ordered by licensed medical doctors or other qualified health providers.

5. Health care providers, including DME suppliers, that provided and supplied items and services to Medicare beneficiaries were referred to as “providers.” Providers were able to apply for and obtain a “provider number.” Providers that received a Medicare number were able to file claims with Medicare to obtain reimbursement for benefits, items, or services provided to beneficiaries.

6. A Medicare claim was required to contain certain important information, including: (a) the 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 as a National Provider Identifier (“NPI”). The claim form could be submitted in hard copy or electronically.

7. Medicare would only pay for items and services that were medically reasonable and necessary, eligible for reimbursement, and provided as represented. Medicare would not pay claims for items and services that were procured through the payment of illegal kickbacks and bribes.

8. CMS contracted with Unified Program Integrity Contractors (“UPICs”) to investigate and prevent waste, fraud, and abuse within Medicare.

9. SafeGuard Services LLC was the Northeastern UPIC (“NE UPIC”).

**Medicare Part B**

10. 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 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.

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

I agree to abide by the Medicare laws, regulations and program instructions that apply to [the provider]. The Medicare laws, regulations, and program instructions are available through the [MAC]. 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 ...).

12. CMS Form 855 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.”

13. Payments under Medicare Part B were often made directly to the provider rather than to the beneficiary. For this to occur, the beneficiary would assign the right of payment to the provider. Once such an assignment took place, the provider would assume the responsibility for

submitting claims to, and receiving payments from, Medicare.

**Durable Medical Equipment**

14. Medicare Part B covered an individual's access to DME, such as off-the-shelf ankle braces, knee braces, back braces, shoulder braces, elbow braces, wrist braces, and hand braces (collectively, "braces"). Off-the-shelf braces required minimal self-adjustment for appropriate use and did not require expertise in trimming, bending, molding, assembling, or customizing to fit the individual.

15. A claim for DME submitted to Medicare qualified for reimbursement only if it was medically necessary for the treatment of the beneficiary's illness or injury and prescribed by a licensed physician or other qualified health care provider.

16. When filing a claim for DME with Medicare, providers were required to submit certain information relating to the beneficiary. The information necessary for a DME claim included:

- a. the type of service provided, identified by a Healthcare Common Procedure Coding System ("HCPCS") code;
- b. the date of service or supply;
- c. the referring physician's Nation Provider Identifier ("NPI");
- d. the charge for such services;
- e. the beneficiary's diagnosis;
- f. the NPI for the DME entity seeking reimbursement; and
- g. certification by the DME provider that the supplies were medically necessary.

Claims seeking reimbursement from Medicare could be submitted in hard copy or electronically.

17. Further, before submitting a claim for an orthotic brace to the DME MAC, a supplier was required to have on file the following:



- a. written documentation of a verbal order or a preliminary written order form from a treating physician;
- b. a detailed written order from the treating physician;
- c. information from the treating physician concerning the beneficiary's diagnosis;
- d. any information required for the use of specific modifiers;
- e. a beneficiary's written assignment of benefits; and
- f. proof of delivery of the orthotic brace to the beneficiary.

18. Medicare and MACs also had specific criteria to establish medical necessity for certain DME items. For example, for knee braces, such criteria included that the beneficiary must be ambulatory and have knee instability documented by certain objective testing; such criteria further specified that knee braces were not reasonable and necessary when patients only demonstrated pain or provided subjective descriptions of instability.

**The Defendant and Relevant Entity and Individuals**

19. CSS Pain Relief, Inc. ("CSS") was a company formed under the laws of Florida. CSS was a DME provider operating nationwide with its principal place of business in Fort Pierce, Florida. CSS was an enrolled provider with Medicare.

20. **DONALD JANI**, last known to be a resident of India, co-owned CSS and held various roles at CSS, including Secretary, CEO, and President.

21. Co-Conspirator-1, last known to be a resident of India, co-owned CSS and held various roles at CSS, including CEO and Secretary.

22. Co-Conspirator-2, a resident of Fort Pierce, Florida, served as CSS's office manager from approximately July 2022 to February 2025.

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

23. Paragraphs 1 through 22 of this Indictment are realleged and incorporated by reference as though fully set forth herein.

24. Beginning at least in or around August 2020, and continuing through at least in or around April 2025, in the District of Vermont, and elsewhere, the defendant, **DONALD JANI**, did knowingly and willfully combine, conspire, confederate, and agree to commit an offense against the United States, that is: 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 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, in violation of Title 18, United States Code, Section 1347.

**Purpose of the Conspiracy**

25. The purpose of the conspiracy was for the defendant, Co-Conspirator-1, Co-Conspirator-2, and others to unlawfully enrich themselves by, among other things: (a) submitting and causing the submission of false and fraudulent claims to Medicare for DME, including DME purportedly provided to beneficiaries located in the District of Vermont and elsewhere, that was medically unnecessary, not legitimately prescribed, and ineligible for reimbursement; (b) submitting and causing the submission of false and fraudulent claims to Medicare for DME, including DME purportedly provided to beneficiaries located in the District of Vermont and elsewhere, that was not in fact provided to beneficiaries; (c) receiving and obtaining the reimbursements paid by Medicare based on the false and fraudulent claims submitted; (d) concealing and causing the concealment of the submission of false and fraudulent claims; and (e)

diverting fraud proceeds for their personal use and benefit, the use and benefit of others, and to further the fraud.

**Manner and Means**

The manner and means by which the defendant and his co-conspirators sought to accomplish the objects and purpose of the conspiracy, included, among other things:

26. It was part of the conspiracy that **DONALD JANI** and Co-Conspirator-1 would and did create and control CSS.

27. It was further part of the conspiracy that **DONALD JANI** and Co-Conspirator-1 opened and maintained a bank account to receive the proceeds of their health care fraud scheme.

28. It was further part of the conspiracy that **DONALD JANI** and his co-conspirators, who were generally based in India, oversaw Co-Conspirator-2's employment activities at the CSS office location in Fort Pierce, Florida.

29. It was further part of the conspiracy that **DONALD JANI** and his co-conspirators would and did knowingly transfer, possess, and use, without lawful authority, the personal identifying information of elderly and disabled citizens in the District of Vermont, and elsewhere, in order for CSS to bill Medicare for fraudulent DME.

30. It was further part of the conspiracy that **DONALD JANI** and his co-conspirators would and did knowingly transfer, possess, and use, without lawful authority, the personal identifying information of doctors and other medical professionals in the District of Vermont, and elsewhere, in order to create the false appearance that the DME claims CSS submitted to Medicare were premised on legitimate medical orders.

31. It was further part of the conspiracy that **DONALD JANI** and his co-conspirators caused unsolicited and deceptive telemarketing calls to be made to Medicare beneficiaries in the District of Vermont, and elsewhere, for the purpose of furnishing DME to those beneficiaries.

32. It was further part of the conspiracy that **DONALD JANI** and his co-conspirators created false and fraudulent orders for braces and glucose monitors in the names of beneficiaries who had no medical need for such DME and then submitted false and fraudulent claims for DME to Medicare in the names of providers who had never prescribed braces and glucose monitors to the specified beneficiaries.

33. It was further part of the conspiracy that **DONALD JANI**, Co-Conspirator-2, and others caused CSS to submit false and fraudulent materials to the UPIC responsible for overseeing the activities of Medicare-enrolled providers based in New England in response to an investigation initiated by the UPIC.

34. It was further part of the conspiracy that **DONALD JANI** and his co-conspirators caused CSS to submit approximately 2,252 claims for reimbursement to Medicare for DME that was purportedly provided to approximately 894 Medicare beneficiaries throughout the United States. In total, CSS billed Medicare approximately \$1.9 million and was, in fact, paid approximately \$790,000 by Medicare for those claims.

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



**COUNTS 2-4**  
**Health Care Fraud**  
**(18 U.S.C. § 1347)**

35. Paragraphs 1 through 22 of this Indictment are realleged and incorporated by reference as though full set forth herein.

36. Beginning at least in or around August 2020, and continuing through at least in or around April 2025, in the District of Vermont, and elsewhere, the defendant, **DONALD JANI**, 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 a health care benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), that is, Medicare, 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.

**Purpose of the Scheme and Artifice**

37. The Purpose of the Conspiracy section of Count 1 of this Indictment is realleged and incorporated by reference as though fully set forth herein as a description of the purpose of the scheme and artifice.

**The Scheme and Artifice**

38. The Manner and Means section of Count 1 of this Indictment is realleged and incorporated by reference as though fully set forth as a description of the scheme and artifice.

**Acts in Execution or Attempted Execution of the Scheme and Artifice**

39. On or about the dates specified below as to each count, in the District of Vermont, and elsewhere, the defendant, **DONALD JANI**, together with others, did knowingly and willfully execute, and attempt to execute, the above-described scheme and artifice to defraud a health care benefit program, in that the defendant submitted and caused the submission of false and fraudulent claims to Medicare, seeking the identified dollar amounts:

Count	Beneficiary	Approx. Date of Service	Approx. Date Claim Submitted	Claim Description	Amount Billed
2	B.A.	11/21/2022	11/29/2022	L0651 – Lumbar-Sacral Orthosis	\$1,039.02
3	M.G.	7/23/2024	7/24/2024	L0651 – Lumbar-Sacral Orthosis	\$1,020.99
4	B.M.	10/29/2024	10/29/2024	L1852 (2 units) – Knee brace L1906 (2 units) – Ankle brace L2397 (2 units)– Compression sleeve	\$2,391

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

**NOTICE OF FORFEITURE**

40. The allegations contained in this Indictment are hereby realleged and incorporated by reference for the purpose of alleging forfeiture as described below.

41. Upon conviction of a violation, or a conspiracy to commit a violation, of Title 18, United States Code, Section 1347, as alleged in this Indictment, the defendant, **DONALD JANI**, shall forfeit to the United States of America, pursuant to Title 18, United States Code, Section

982(a)(7), any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

42. If any of 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 difficult,

the defendant shall forfeit to the United States any other property of the defendant, up to the value of the property described above, pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b)(1) and Title 28, United States Code, Section 2461(c).

All pursuant to Title 21, United States Code, Section 853(a), Title 18, United States Code, Sections 982(a)(1) and 982(a)(7), and Title 28, United States Code, Section 2461(c).

A TRUE BILL.

Dated:

[REDACTED]  
Foreperson of the Grand Jury

MICHAEL P. DRESCHER  
Acting United States Attorney  
District of Vermont

LORINDA LARYEA  
Acting Chief  
United States Department of Justice  
Criminal Division, Fraud Section

By:



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