ORIGINAL

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

UNITED STATES OF AMERICA

v.

LARRY LORENTSEN (01)
BRANDON LORENTSEN (02)

NO.
3-25CR-276 N

INFORMATION

The United States Attorney charges that:

General Allegations

At all times material to this Information,

The Defendant and Related Entities

1. Defendant **Larry Lorentsen** was a resident of the Middle District of Florida and the owner of Progressive Supplies Stat LLC ("Progressive"). Defendant **Larry Lorentsen** also helped recruit individuals to serve as the purported owner listed on paperwork of Origin Medical LLC ("Origin"), Company A, Company B, Advanced Medical Diagnostics of Texas, LLC ("Advanced"), and other entities.

2. Defendant **Brandon Lorentsen** was a resident of the Middle District of Florida, an employee of Progressive, and helped recruit individuals to serve as the purported owner listed on the paperwork of Company B and Advanced.

3. Origin was a durable medical equipment ("DME") company located in the Southern District of Florida that billed Medicare for orthotic braces.

4. Company A was a DME company located in the Southern District of Texas that billed Medicare for orthotic braces.

5. Company B was a DME company registered and located in the Southern District of Florida that billed Medicare for orthotic braces.

6. Advanced was a purported laboratory located in the Northern District of Texas that billed Medicare for certain COVID-19 test kits.

7. Progressive was a drop-shipping company located in the Middle District of Florida that shipped DME on behalf of Origin, Company B, and Company A and over-the-counter COVID-19 test kits on behalf of Advanced.

8. Although not listed on behalf of documents filed for Origin, Company A, Company B, and Advanced with the Secretaries of State, the Medicare Program ("Medicare"), and banks, Coconspirator 1 was the true owner and operator of Origin, Company A, Company B, Advanced, and Progressive.

The Medicare Program

9. Medicare was a federal health care program providing benefits to individuals who were the age of 65 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 Centers for Medicare Services ("CMS"), oversaw and administered Medicare. Individuals who received benefits under Medicare were commonly referred to as Medicare "beneficiaries."

10. 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).

11. Medicare covered, among other things, medical services provided by physicians, medical clinics, laboratories, and other qualified health care providers, and office services and outpatient care—including the ordering of diagnostic testing—that were medically necessary and ordered by licensed medical doctors or other qualified health care providers.

12. Physicians, clinics, DME companies, 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.

13. To receive Medicare reimbursement, providers had to apply and execute a written provider agreement, known as CMS Form 855. The Medicare application was required to be signed by an authorized representative of the provider and required providers to disclose all owners and managing employees. The application contained certifications that the provider agreed to abide by the Medicare laws and regulations, including the Federal Anti-Kickback Statute, and 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."

14. Medicare paid for claims only if the items or services were medically

reasonable, medically necessary for the treatment or diagnosis of the beneficiary's illness or injury, documented, and actually provided as represented to Medicare. Medicare would not pay for testing, items or services that were procured in violation of the Federal Anti-Kickback Statute, including the provision prohibiting the purchase, sale, and distribution of Medicare beneficiary identification numbers.

Medicare Beneficiary Identification Numbers

15. Each Medicare beneficiary was identified with a unique beneficiary identification number. These beneficiary identification numbers were used to determine a beneficiary's eligibility for Medicare benefits and to submit claims to Medicare seeking reimbursement for covered benefits, items, and services. Health Insurance Claim Numbers ("HICNs") and Medicare Beneficiary Identifiers ("MBIs") were two types of Medicare beneficiary identification numbers.

16. HICNs were typically comprised of the beneficiary's social security number and often included one or more additional letters. In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act ("MACRA"), which mandated that CMS phase out the use of social security numbers in the assignment of Medicare beneficiary identification numbers.

17. Following the passage of MACRA, CMS began to assign Medicare beneficiaries MBIs, which were comprised of a unique series of eleven randomly generated numbers and letters. MBIs, like HICNs, were used to identify qualifying beneficiaries in all Medicare transactions such as billing and claim submissions. One purpose of using this randomly generated series of numbers and letters was to improve

patient identity protection and prevent identify theft. According to CMS, personal identity theft affected a large and growing number of senior citizens. CMS implemented the new MBIs in an effort to combat identity theft and safeguard taxpayer dollars.

Over-the-Counter COVID-19 Test Kits

18. Beginning on or about April 4, 2022, and continuing through the duration of the COVID-19 public health emergency, Medicare covered and paid for over-the-counter COVID-19 test kits at no cost to beneficiaries with Medicare Part B and those with Medicare Advantage plans. This program was intended to ensure Medicare beneficiaries had access to COVID-19 test kits they needed to stay safe and healthy during the COVID-19 pandemic. Eligible providers capable of providing ambulatory health care services were permitted to distribute to Medicare beneficiaries over-the-counter COVID-19 test kits that were approved, authorized, or cleared by the United States Food and Drug Administration.

19. Medicare would not pay for more than eight over-the-counter COVID-19 test kits, per calendar month, per Medicare beneficiary. Providers could distribute over-the-counter COVID-19 test kits only to Medicare beneficiaries who requested them. Providers were required to keep documentation showing a Medicare beneficiary's request for the test kits.

20. Medicare did not cover over-the-counter COVID-19 test kits billed by durable medical equipment suppliers or providers who distributed over-the-counter COVID-19 test kits to Medicare beneficiaries during an inpatient stay at a hospital or skilled nursing facility.

Durable Medical Equipment

21. 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, "orthotic braces" or "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.

22. 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 provider.

COUNT ONE
Conspiracy to Commit Health Care Fraud
(Violation of 18 U.S.C. § 1349 (18 U.S.C. § 1347))

23. All previous paragraphs of this information are realleged and incorporated by reference as if fully alleged herein.

24. Beginning in or around October 2021, and continuing through in or around July 2024, the exact dates being unknown, in the Dallas Division of the Northern District of Texas, and elsewhere, **Larry Lorentsen** and **Brandon Lorentsen** did knowingly and willfully combine, conspire, confederate, and agree with each other and others, known and unknown to the United States Attorney, 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.

Objects and Purposes of the Conspiracy

25. It was an object and purpose of the conspiracy for **Larry Lorentsen**, **Brandon Lorentsen**, and their coconspirators to unlawfully enrich themselves and others by, among other things: (1) paying kickbacks and bribes in exchange for completed prescriptions and other documents required to submit claims for braces ("doctors' orders") for Medicare beneficiaries for braces that were medically unnecessary, not eligible for Medicare reimbursement, and/or not provided as represented; (2) purchasing, selling, and distributing, and arranging for the purchase, sale, and distribution, of Medicare beneficiary information, including beneficiary names, dates of birth, social security numbers, HICNs, and MBIs; (3) purchasing and shipping over-the-counter COVID-19 test kits to Medicare beneficiaries who did not want and/or did not request them; (4) submitting and causing the submission of false and fraudulent claims for health care benefits to Medicare; (5) concealing and causing the concealment of false and fraudulent claims to Medicare; and (6) diverting fraud proceeds for their personal use and benefit, the use and benefit of others, and to further the fraud.

Manner and Means of the Conspiracy

26. The manner and means by which the defendants and their coconspirators sought to accomplish the objects and purposes of the conspiracy included, among other things, the following:

27. In an effort to conceal the true ownership and operation of Origin, Company A, Company B, and Advanced, **Larry Lorentsen**, **Brandon Lorentsen**, and other coconspirators helped recruit nominee owners to list on Medicare and other required paperwork as the owners of Origin, Company A, Company B, and Advanced on behalf of Coconspirator 1. The coconspirators provided nominee owners with funds to purchase the companies and coached the nominee owners through the purchase of the companies.

28. Once the nominee owners purchased the companies, the nominee owners falsely certified to Medicare that they were the owners of the company and that they were the only owners and managing employees of these companies, would comply with all Federal regulations and Federal laws, including that they would not knowingly present or cause to be presented false and fraudulent claims for payment by Medicare, and would not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

29. The coconspirators caused the submission of Medicare enrollment forms for Origin, Company A, Company B, and Advanced that falsely listed nominee owners as the sole owner of the companies when, in truth, Coconspirator 1 was the owner and operator of the companies.

30. On or about December 29, 2022, **Brandon Lorentsen** certified to Medicare that he was the sole owner and managing employee of Advanced, would comply with all Federal regulations and Federal laws, including the Federal Anti-Kickback Statute, and that he would not knowingly present or cause to be presented a false and fraudulent claim

for payment by Medicare and would not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

31. The coconspirators obtained Medicare beneficiary information, including beneficiary names, dates of birth, social security numbers, Heath Insurance Claim Numbers ("HICNs"), and Medicare Beneficiary Identifiers ("MBIs"), without authorization from Medicare beneficiaries. This information was supplied to **Larry Lorentsen**, **Brandon Lorentsen**, and others, so that the coconspirators, through Origin, Company A, Company B, and Advanced, could bill Medicare for durable medical equipment ("DME") and COVID-19 test kits and ship those products to Medicare beneficiaries in furtherance of the scheme.

32. The coconspirators, facilitated by **Larry Lorentsen** and **Brandon Lorentsen**, provided, and caused the provision of, DME to beneficiaries that were procured through the payment of illegal kickbacks and bribes, were not eligible for reimbursement, were medically unnecessary, and that the beneficiaries often did not want or request.

33. The coconspirators purchased Medicare beneficiary information, including beneficiary names, dates of birth, social security numbers, HICNs, and MBIs to use in the submission of false and fraudulent claims to Medicare.

34. **Brandon Lorentsen** and his coconspirators submitted and caused the submission of false and fraudulent claims to Medicare for over-the-counter COVID-19 test kits that that were procured through the payment of illegal kickbacks and bribes,

were not eligible for reimbursement, and that the beneficiaries often did not want or request.

35. **Larry Lorentsen** and certain of his coconspirators directed nominee owners to wire funds to bank accounts associated with other coconspirators, including purported marketing companies and coconspirators located overseas, including Coconspirator 1.

36. **Brandon Lorentsen** and certain of his coconspirators wired funds to bank accounts associated with other coconspirators, including purported marketing companies and coconspirators located overseas, including Coconspirator 1.

37. Beginning in or around October 2021 and continuing through in or around July 2024, **Larry Lorentsen** and his coconspirators, through Origin, Company A, and Company B, unlawfully submitted or caused to be submitted approximately $63.2 million in false and fraudulent claims to Federal health care programs, including Medicare, for prescriptions for DME, including orthotic braces. Medicare paid approximately $29.4 million on these false and fraudulent claims. These prescriptions, as **Larry Lorentsen** knew and intended, were, among other things, medically unnecessary, not legitimately prescribed, not wanted, not provided as represented, not eligible for reimbursement, and/or induced through unlawful kickbacks and bribes in violation of the Federal Anti-Kickback Statute.

38. Beginning in or around December 2022 and continuing through in or around April 2023, **Brandon Lorentsen** and his coconspirators, through Advanced, unlawfully submitted and caused to be submitted approximately $7.3 million in false and

fraudulent claims to Federal health care programs, including Medicare, for certain over-the-counter COVID-19 test kits. Medicare paid approximately $2.9 million on these false and fraudulent claims. These claims, as **Brandon Lorentsen** knew and intended, were for over-the-counter COVID-19 test kits that were, among other things, not wanted, not eligible for reimbursement, and/or induced through unlawful kickbacks and bribes in violation of the Federal Anti-Kickback Statute.

All in violation of 18 U.S.C. § 1349.

Forfeiture Notice
(18 U.S.C. § 982(a)(7) and 28 U.S.C. § 2461)

39. Pursuant to 18 U.S.C. § 982(a)(7) and 28 U.S.C. § 2461, upon conviction of Count One, **Larry Lorentsen** and **Brandon Lorentsen** shall forfeit to the United States, any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to Count One.

40. Pursuant to 21 U.S.C. § 853(p), as incorporated by 28 U.S.C. § 2461(c), if any of the property described above, as a result of any act or omission of a defendant:

a. cannot be located upon the exercise of due diligence;

b. has been transferred, 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 which cannot be divided without difficulty,

the United States intends to seek forfeiture of any other property of the defendant up to the value of the forfeitable property described above.

Respectfully Submitted:

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