

JUN 24 2025 PM 2:42
FILED - USDC - FL MD - JAX

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

UNITED STATES OF AMERICA

v.

CASE NO. 3:25-cr- **130-WWB-PPB**
18 U.S.C. § 371

WILLIAM BALSAMO

INFORMATION

The United States Attorney charges:

COUNT ONE
(Conspiracy)

A. Introduction

At times material to this Information:

1. WILLIAM BALSAMO resided in the Middle District of Florida.
2. BALSAMO was the Chief Financial Officer and co-owner of Call MD Plus, Inc. ("Call MD Plus"), a purported telemedicine software company which operated and was headquartered in Tampa, Florida, in the Middle District of Florida.
3. The Medicare Program ("Medicare") was a federally funded health insurance 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. Individuals who received Medicare benefits were called “beneficiaries.”

4. 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).

5. Medicare programs covering different types of benefits were separated into different program “parts.” Medicare Part B covered physician services as well as, among other things, genetic testing (such as cancer genomic (“CGx”) testing and pharmacogenetic (“PGx”) testing) and certain medical equipment, such as durable medical equipment (“DME”), that were medically necessary. Medicare Part D provided prescription drug benefits and helped Medicare beneficiaries pay for prescription drugs.

6. Under Part B, DME companies, genetic testing laboratories, physicians, and other health care providers that provided services to Medicare beneficiaries were referred to as “providers.” To participate in Medicare, providers were required to submit an application in which the providers agreed to comply with all Medicare-related laws, rules, and regulations. If Medicare approved a provider’s application, Medicare assigned the provider a

Medicare “provider number.” A health care provider with a Medicare provider number could file claims with Medicare to obtain reimbursement for medically necessary items and services rendered to beneficiaries. Medicare providers were given access to Medicare manuals and service bulletins describing billing procedures, rules, and regulations.

7. Medicare reimbursed DME providers, genetic testing laboratories, and other health care providers for medically necessary Part B items, tests, and services rendered to beneficiaries. To receive payment from Medicare, providers submitted or caused the submission of claims to Medicare, either directly or through a billing company.

8. Medicare would pay a claim for the provision of DME only if the equipment was medically necessary, ordered by a licensed provider, and actually provided to the beneficiary.

9. Medicare did not cover laboratory or diagnostic testing, including CGx and PGx, that was “not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” 42 U.S.C. § 1395y(a)(1)(A). Except for certain statutory exceptions, Medicare did not cover “examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint or injury.” 42 C.F.R. § 411.15(a)(1).

10. If diagnostic testing was necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, Medicare imposed additional requirements before covering the testing. 42 C.F.R. § 410.32(a) provided that “all diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary’s specific medical problem.” Laboratory tests not ordered by the physician treating the beneficiary were not reasonable and necessary.

11. Medicare Part B claims were required to be properly documented in accordance with Medicare rules and regulations. Medicare would not reimburse providers for claims that were procured through the payment of kickbacks and bribes.

12. In order to receive Part D benefits, a beneficiary enrolled in a Medicare drug plan. Medicare Part D plans were offered through private insurance companies, or “sponsors,” that were approved by Medicare. A beneficiary in a Medicare drug plan could fill a prescription at a pharmacy and use his or her plan to pay for some or all of the prescription.

13. A pharmacy could participate in Medicare Part D and receive reimbursements for prescription medications provided to Medicare beneficiaries by entering into a retail network agreement directly with a Part D plan, or through one or more Pharmacy Benefit Managers (“PBMs”). PBMs acted on behalf of one or more Medicare Part D plans. Through a plan’s PBM, a pharmacy could join the plan’s network. When a Part D beneficiary presented a prescription to a pharmacy, the pharmacy submitted a claim either directly to the plan or to a PBM that represented the beneficiary’s Medicare drug plan. The plan or PBM determined whether the pharmacy was entitled to payment for each claim and periodically paid the pharmacy for outstanding claims. The drug plan’s sponsor reimbursed the PBM for its payments to the pharmacy. Medicare, through CMS, compensated the Medicare drug plan sponsors. Medicare would not pay for items or services that were not medically necessary, or that were procured through kickbacks and bribes.

B. The Conspiracy

14. Beginning on an unknown date, but not later than in or around January 2019, and continuing through in or around September 2021, in the Middle District of Florida and elsewhere, the defendant,

WILLIAM BALSAMO,

did knowingly and willfully combine, conspire, confederate, and agree with Luis Lacerda, Omar Solari, Patrick O'Brien, Joelson Viveros, and others known and unknown to the United States, to commit certain offenses against the United States, that is,

- a. to defraud the United States by cheating the United States government and any of its agencies and departments out of money and property, and by impairing, impeding, obstructing, and defeating through deceitful and dishonest means, the lawful government functions of HHS and CMS in their administration and oversight of Medicare;
- b. to violate 42 U.S.C. § 1320a-7b(b)(1)(B), by knowingly and willfully soliciting and receiving any remuneration, including kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, in return for purchasing, leasing, ordering, and arranging for and recommending purchasing, leasing, and ordering any good, facility, service, and item for which payment may be made in whole and in part by a Federal health care program; and
- c. to violate 42 U.S.C. § 1320a-7b(b)(2)(B), by knowingly and willfully offering to pay, and offering and paying, any remuneration, specifically, kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, to any person to induce such person to purchase, lease,

order, and arrange for and recommend purchasing, leasing, and ordering any good, facility, service, and item for which payment may be made in whole and in part under a Federal health care program.

C. Manner and Means

15. The manner and means by which the defendant and his co-conspirators sought to accomplish the object of the conspiracy included, among others, the following:

a. It was part of the conspiracy that BALSAMO and others would and did solicit, agreed to receive, and received kickbacks and bribes from pharmacies, clinical labs, and DME companies (collectively “PROVIDERS”) in the Middle District of Florida and elsewhere in exchange for prescriptions and medical orders for DME and laboratory testing that were medically unnecessary and ineligible for Medicare reimbursement.

b. It was further part of the conspiracy that the PROVIDERS paid Call MD Plus illegal kickbacks and bribes in the form of a set fee per Medicare beneficiary in exchange for the signed prescriptions or orders returned to the PROVIDERS.

c. It was further a part of the conspiracy that BALSAMO and others would and did conceal the kickbacks and bribes in sham contracts and invoices between Call MD Plus and the PROVIDERS by describing the

payments as “credits,” “consults,” and “completed uploaded records,” disguising their true nature, that is, that they were kickback payments for the creation of medically unnecessary prescriptions.

d. It was further part of the conspiracy that BALSAMO and others provided guidance to the PROVIDERS and telemarketers working with the PROVIDERS regarding the recruitment of Medicare beneficiaries for fraudulent prescriptions and medical orders.

e. It was further part of the conspiracy that BALSAMO and others worked with medical staffing companies to find medical practitioners willing to sign prescriptions and medical orders in exchange for kickbacks and bribes.

f. It was further part of the conspiracy that BALSAMO and others would and did facilitate the creation of prescriptions and medical orders based on Medicare beneficiary information provided by telemarketers through the Call MD Plus web-based telemedicine platform known as “Blue Mosaic,” which was designed to fraudulently make it appear as if the medical practitioners had examined and treated the Medicare beneficiaries in accordance with telemedicine regulations.

g. It was further part of the conspiracy that the medical practitioners contracted with Call MD Plus signed the prescriptions and

medical orders even though they typically had no relationship with the Medicare beneficiaries, were not treating the Medicare beneficiaries, and did not conduct proper telemedicine visits, in exchange for kickbacks and bribes paid on a per-prescription or -medical order basis.

h. It was further part of the conspiracy that BALSAMO and others caused the medically unnecessary prescriptions and medical orders to contain a fraudulent attestation next to the medical practitioner's signature, falsely stating that the prescriptions and medical orders had been created pursuant to a legitimate prescriber-patient relationship and in accordance with telemedicine requirements.

i. It was further part of the conspiracy that after the medically unnecessary prescriptions and medical orders generated from kickbacks were sent back to the PROVIDERS, these prescriptions and medical orders were billed to the Medicare program, sometimes including multiple months of refills, despite the lack of medical necessity.

j. It was further part of the conspiracy that from approximately January 2019 through September 2021, the PROVIDERS paid illegal kickbacks of approximately \$9,140,554 to Call MD Plus, during which time the defendant received payments of approximately \$739,462.82.

k. It was further part of the conspiracy that the conspirators would and did divert fraud proceeds for their own personal use and benefit, the use and benefit of others, and to further the fraud.

l. It was further part of the conspiracy that the conspirators would and did perform acts and make statements to hide and conceal, and cause to be hidden and concealed, the purpose of the conspiracy and the acts committed in furtherance thereof.

E. Overt Acts

16. In furtherance of the conspiracy and to accomplish its goals, BALSAMO and his co-conspirators committed and caused the commission of one or more of the following acts in the Middle District of Florida and elsewhere:

a. On or about September 28, 2020, BALSAMO sent an email to a Call MD Plus employee approving a new “closing statement” and script for use by call center telemarketers, who were not physicians, with Medicare beneficiaries. Among other things, the script falsely claimed that “[a] doctor may use this information as part of a consultation with you that may result in a prescription,” when in reality, the Call MD Plus contracted telemedicine doctors rarely if ever consulted with the beneficiaries, and signed the prescriptions and medical orders without regard for medical necessity.

b. On or about October 22, 2020, BALSAMO signed a fraudulent “Software Licensing Agreement” (SLA) with Cloverfield International, a holding company for Fresh Pond Rx (“Fresh Pond”), a PROVIDER based in New York owned by co-conspirators Luis Lacerda, Omar Solari, and Patrick O’Brien, for the purpose of having medically unnecessary prescriptions signed by Call MD Plus contracted doctors and sent to Fresh Pond, which then paid a kickback to Call MD Plus for each signed prescription.

c. On or about October 22, 2020, BALSAMO signed a fraudulent SLA with White Bunny Enterprises, a holding company for White River Pharmacy (“White River”), a PROVIDER based in Arkansas owned by co-conspirators Luis Lacerda and Omar Solari, for the purpose of having medically unnecessary prescriptions signed by Call MD Plus contracted doctors and sent to White River, which then paid a kickback to Call MD Plus for each signed prescription.

d. On or about October 23, 2020, BALSAMO caused a Call MD Plus employee to send an email to co-conspirator Joelson Viveros, one of the owners of South Bend Specialty Pharmacy, a PROVIDER based in Indiana, containing a \$9,000 invoice as prepayment of 100 purported

“Membership Credit Blocks” for \$90 each, which in reality represented prepayment of kickbacks on a per-prescription basis.

All in violation of 18 U.S.C. § 371.

FORFEITURE

1. The allegations contained in Count One are incorporated by reference for the purpose of alleging forfeitures pursuant to the provisions of 18 U.S.C. § 982(a)(7).

2. Upon conviction of a conspiracy to violate section 42 U.S.C. § 1320-7b(b)(1)(A) and/or 42 U.S.C. § 1320-7b(b)(2)(A), in violation of 18 U.S.C. § 371, the defendant shall forfeit to the United States, pursuant to 18 U.S.C. § 982(a)(7), any property, real or personal, which constitutes or is derived, directly or indirectly, from gross proceeds traceable to the offense.

3. The property to be forfeited includes, but is not limited to, an order of forfeiture in the amount of \$739,462.82, which represents the proceeds the defendant received as a result of the offense.

4. If any of the property described above, 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 which cannot be divided without difficulty,

the United States of America shall be entitled to forfeiture of substitute property under the provisions of 21 U.S.C. § 853(p), as incorporated by 18 U.S.C. § 982(b)(1).

GREGORY W. KEHOE
United States Attorney

By: 
David B. Mesrobian
Assistant United States Attorney

By: 
Michael J. Coolican
Assistant United States Attorney
Deputy Chief, Jacksonville Division

LORINDA LARYEA
Acting Chief
Criminal Division, Fraud Section

By:  for
Gary A. Winters
Acting Assistant Chief