USAO2024R00947/JN

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA	:	Hon. James B. Clark, III
	:	
v.	:	Magistrate. No. 26-12103
	:	
JEREMY JAMES	:	**CRIMINAL COMPLAINT**

I, Special Agent Agnieszka Zajac, being duly sworn, state the following is true and correct to the best of my knowledge and belief:

SEE ATTACHMENT A

I further state that I am a Special Agent with the Department of Health and Human Services, Office of the Inspector General, and that this complaint is based on the following facts:

SEE ATTACHMENT B

continued on the attached pages and made a part hereof.

s/*Agnieszka Zajac*
Agnieszka Zajac, Special Agent
Dept. of Health and Human Services

Special Agent Agnieszka Zajac attested to this Affidavit by telephone pursuant to F.R.C.P. 4.1(B)(2)(A) on this 17th day of June, 2026.

Hon. James B. Clark, III
United States Magistrate Judge

ATTACHMENT A

From in or around June 2024 through in or around December 2025, in Hudson County, in the District of New Jersey, and elsewhere, the defendant,

JEREMY JAMES,

knowingly and willfully executed and attempted to execute a scheme and artifice to defraud health care benefit programs, namely, Medicare, a health care benefit program as defined under Title 18, United States Code, Section 24(b), and to obtain, by means of false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, said health care benefit programs, 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.

ATTACHMENT B

I, Agnieszka Zajac, am a Special Agent of the Department of Health and Human Services, Office of the Inspector General. The information contained in the complaint is based upon my personal knowledge, as well as information obtained from other sources, including: (a) statements made or reported by various witnesses with knowledge of relevant facts; (b) my review of publicly available information; and (c) my review of evidence, including business records, bank records, and other documents. Because this complaint is being submitted for a limited purpose, I have not set forth every fact that I know concerning this investigation. Where the contents of documents and the actions and statements of others are reported, they are reported in substance and in part, except where otherwise indicated. Where I assert that an event took place on a particular date, I am asserting that it took place on or about the date alleged.

Relevant Individuals and Entities

1. At all times relevant to this Criminal Complaint:

a. Defendant Jeremy James ("JAMES") whose last known residence was in or around Brooklyn, New York, who owned and operated Omnis Medical Services ("OMNIS"), which was a purported durable medical equipment ("DME") distributor located in Jersey City, New Jersey.

b. OMNIS purportedly prepared and supplied DME products including but not limited to back, leg, and arm braces, which were prescribed to treat a variety of conditions including but not limited to musculoskeletal injuries, chronic joint pain, and post-surgical rehabilitation. OMNIS also purportedly prepared and supplied glucose monitors and sensors, which were another form of DME prescribed to treat diabetes.

c. Individual-1 was a licensed orthotist who would contract his or her services to DME companies.

d. Provider-1 was an internal medicine provider located in Southgate, Michigan.

e. Provider-2 was a primary care provider located in Middletown, New York.

f. Provider-3 was an emergency medicine provider located in Middletown, New York.

g. Beneficiary-1 was a Medicare beneficiary who was a patient of Provider-1 located in Dearborn Heights, Michigan.

h. Beneficiary-2 was a Medicare beneficiary who was a patient of Provider-2 located in Walden, New York.

i. Beneficiary-3 was a Medicare beneficiary who was a patient of Provider-3 located in Warwick, New York.

The Medicare Program

2. The Medicare Program ("Medicare") was a federally funded health care program, which provided payment for reasonable and medically necessary medical services for certain individuals, primarily the elderly, blind, and disabled. Medicare was administered by the United States Department of Health and Human Services, Center for Medicare and Medicaid Services ("CMS"). Individuals who received Medicare benefits were referred to as Medicare beneficiaries.

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

4. 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.

5. 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.

6. In order for a supplier of DME services 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.

7. 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 to 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, including, but not limited to, only submitting claims for reimbursement that were medically necessary and prescribed by a licensed medical provider; (4) acknowledge that the payment of a claim by Medicare was 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.

The Health Care Fraud Scheme

8. From in or around September 2024 through in or around November 2025, JAMES fraudulently billed Medicare for medically unnecessary DME prescriptions that he obtained on behalf of beneficiaries who did not need or want the DME. To do so, JAMES employed call centers—many of which were located abroad—to make unsolicited calls to Medicare beneficiaries to convince them to obtain DME products from OMNIS.

9. Despite those Medicare beneficiaries telling representatives of OMNIS that they did not need the DME products OMNIS offered and did not want OMNIS to order them, OMNIS nevertheless ordered and sent those beneficiaries the medically unnecessary DME products.

10. OMNIS included certain forms accompanying the medically unnecessary DME orders that listed beneficiaries' medical providers' information even though those providers did not order the product or otherwise authorize the prescription. Moreover, in the case of glucose sensors being ordered, some of the OMNIS orders received by beneficiaries listed their primary care doctor even though their diabetes were treated and monitored by a different specialist provider.

11. The investigation has revealed that JAMES carried out the scheme by generating prefilled DME prescription order forms for each Medicare beneficiary that OMNIS contacted through call centers in the manner described above, and then JAMES submitted those prefilled prescriptions to numerous medical providers for signature even if the beneficiary had said that they did not need or want the DME products.

12. JAMES would then repeatedly call those provider offices to obtain the provider's signature on prescription request forms from a staff member without regard for medical necessity and without the beneficiary actually having been examined or having need for the prescription. Once he received the signed form, JAMES would submit the order for reimbursement from Medicare.

Goal of the Scheme

13. The goal of the health care fraud scheme was for JAMES to unlawfully enrich himself by submitting and causing the submission of false and fraudulent claims to Medicare for reimbursement of DME prescriptions that were not requested, signed, or authorized by a licensed medical provider nor requested or needed by the receiving beneficiary.

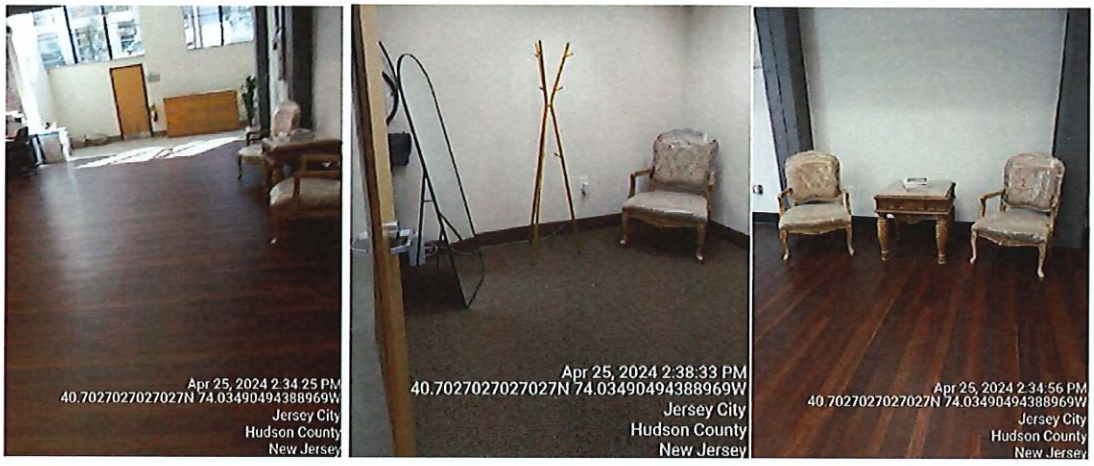
Manner and Means of the Scheme

OMNIS's Medicare Enrollment Misrepresentations

14. It was part of the scheme that JAMES enrolled OMNIS with CMS by misrepresenting that OMNIS's business comported with governing laws and regulations required for DME companies to enroll as a Medicare provider. Those misrepresentations included:

a. On or about June 20, 2024, JAMES submitted certain enrollment paperwork to CMS on behalf of OMNIS which falsely stated that OMNIS employed Individual-1 as a licensed orthotist on staff—which was a required under Medicare guidelines—even though Individual-1 did not work at OMNIS and neither JAMES nor anyone associated with OMNIS referred a single beneficiary or DME order to Individual-1.

b. While JAMES was required under Medicare rules to maintain a physical, commercially accessible office space of at least 200 feet that is staffed and open to the public a minimum of 30 hours per week, inspector site visits from prior to OMNIS's opening revealed a barely furnished minimal space that was not equipped for patients to be evaluated or for DME products to be assembled or stored, as shown in the photographs below:



OMINIS's Medically Unnecessary DME Prescriptions

15. It was also part of the scheme that JAMES, through OMINIS, solicited medically unnecessary DME prescriptions by contacting beneficiaries and providers to obtain provider signatures on prefilled DME prescription forms and then billing Medicare for reimbursement. Certain examples are provided below.

Beneficiary-1

16. In or around November 2024, representatives from OMINIS contacted Beneficiary-1 to provide DME products but Beneficiary-1 told the representative that he or she did not want or need the product. Nevertheless, on or about November 25, 2024, JAMES submitted a prefilled DME prescription order to the office of Provider-1 purportedly on behalf of Beneficiary-1.

17. Shortly thereafter, JAMES submitted a claim to Medicare for a DME order for Beneficiary-1 from Provider-1's office despite Provider-1 having no record of the order and Provider-1 not authorizing the prescription. Beneficiary-1 then received DME products from OMINIS despite never ordering or needing them

Beneficiary-2

18. In or around December 2024, representatives from OMINIS contacted Beneficiary-2 to provide DME products but Beneficary-2 told the representative that he or she did not want or need the product because he/she was in hospice care. Nevertheless, on or about December 6, 2024, JAMES submitted a prefilled DME prescription order for Beneficiary-2 to the office of Provider-2.

19. Shortly thereafter, JAMES submitted a claim to Medicare for a DME order for Beneficiary-2 from Provider-2's office which contained a signature that matched Provider-2's signature even though Provider-2 did not evaluate Beneficiary-2 for DME products. Approximately three months later, JAMES called Provider-2's office to obtain a signature on another DME prescription form for Beneficiary-2 even though Beneficiary-2 had passed away.

Beneficiary-3

20. On or about December 10, 2024, JAMES submitted a prefilled DME prescription order to the office of Provider-3 purportedly on behalf of Beneficiary-3. The investigation has revealed that Beneficiary-3 had never spoken to anyone at OMINIS let alone requested a DME prescription from OMINIS, Provider-3, or any other medical provider

21. Shortly thereafter, JAMES submitted a claim to Medicare for a DME order from Provider-3's office which contained a signature that matched Provider-3's signature even though Provider-3 did not have any record of the prescription in Beneficiary-3's patient file, did not recall authorizing the prescription, and told law enforcement that he/she would not have authorized the prescription.

OMNIS's CMS Audit Misrepresentations

22. Notably, during the time period that JAMES submitted these fraudulent claims to Medicare on behalf of Beneficiaries-1 through 3 and numerous other Medicare beneficiaries, JAMES received numerous complaints from beneficiaries and medical providers about OMNIS billing for and providing DME that beneficiaries did not want or need and which their medical providers did not authorize. Despite receiving these complaints, JAMES continued to bill Medicare for medically unnecessary DMEs.

23. After receiving numerous beneficiary complaints concerning OMNIS, CMS audited OMNIS beginning in or around March 2025 and, as a result of that audit, Medicare terminated OMNIS's enrollment in Medicare in or around May 2025.

24. OMNIS was reinstated with Medicare in or around October 2025, and JAMES proceeded to "back bill" Medicare for medically unnecessary DME prescription orders filled from in or around June 2025 through in or around October 2025, *i.e.*, during the time period OMNIS was barred from submitting DME reimbursement claims to Medicare.

25. Then, in or around November 2025, CMS initiated another audit to investigate OMNIS's DME billing practices.

26. In connection with the November 2025 audit, JAMES submitted to CMS false documents to conceal the scheme from Medicare and retain the proceeds of the scheme. Specifically, in his rebuttal, JAMES submitted letters on OMNIS letterhead purportedly written and signed by beneficiaries, including but not limited to the spouses and health care proxies for Beneficiary-1 and Beneficiary-2, effectively retracting their complaints.

27. In those doctored letters, JAMES falsely represented to CMS that the beneficiaries' spouses believed that either they or the beneficiaries reached out to OMNIS, did not receive unsolicited calls, and wanted and needed the DME products. Law enforcement showed the letters purportedly signed by the spouses of Beneficiary-1 and Beneficiary-2 to them and each said that they did not write nor sign the letters.

28. On or about March 11, 2026, Medicare denied OMNIS's rebuttal and upheld the suspension of OMNIS's enrollment.

29. In total, from in or around September 2024 through in or around November 2025, JAMES billed Medicare for approximately $3.7 million in reimbursements for DME prescription orders and received approximately $1.7 million from Medicare.