UNITED STATES DISTRICT COURT

DISTRICT OF OREGON

EUGENE DIVISION

UNITED STATES OF AMERICA	**6:26-cr-00228-MC**
v.	**INFORMATION**
MEHRDAD GERAMI,	**18 U.S.C. § 1349 (Conspiracy to Commit Health Care Fraud)**
Defendant.	**Forfeiture Allegation**

THE UNITED STATES ATTORNEY CHARGES:

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

At all times material to this Information:

INTRODUCTORY ALLEGATIONS

1. MEHRDAD GERAMI ("GERAMI"), defendant herein, owned and operated COASTAL DIAGNOSTIC TESTING GROUP ("CDTG") and COASTAL DIAGNOSTIC ("CD"), both of which businesses engaged in conducting medical sleep study testing. CDTG and CD operated locations in Coos Bay, Brookings, Reedsport, Florence, and Roseburg, Oregon, and utilized joint resources including employees, an office manager, and a medical biller.

Sleep Study Definitions and Billing Codes

2. Polysomnography, known as a sleep study, is a non-invasive, overnight exam that

allows doctors to monitor your brain and body function while you sleep. Sleep studies help doctors diagnose sleep disorders such as sleep apnea, periodic limb movement disorder, narcolepsy, restless legs syndrome, insomnia, and nighttime behaviors like sleepwalking and REM sleep behavior disorder. Testing can be done in a lab setting or at home, dependent upon the types of sleep disorders being examined. In certain circumstances, veterans and beneficiaries can obtain sleep studies and related equipment through community providers.

3. The Current Procedural Terminology (CPT) codes offer healthcare providers a uniform language for coding and billing medical services and procedures to streamline reporting, increase accuracy and efficiency. CPT codes are also used for administrative management purposes such as claims processing and developing guidelines for medical care review. The CPT terminology is the most widely accepted medical nomenclature used across the country to report medical, surgical, radiology, laboratory, anesthesiology, genomic sequencing, evaluation and management (E/M) services under public and private health insurance programs.

4. Sleep study CPT codes utilized in this investigation are highlighted below. Of note, the first two codes, 95810 and 95811, represent the vast majority of CDTG's billings in this investigation and require the patient to be attended by a technologist:

95811: Polysomnography, sleep staging with 4 or more additional parameters of sleep, with initiation of Continuous Positive Airway Pressure (CPAP) therapy[1] or bilevel ventilation, attended by a technologist.

95810: Polysomnography, sleep staging with 4 or more additional parameters of sleep, attended by a technologist.

95807: Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or

[1] CPAP therapy is a common medical therapy to treat breathing disorders that affect sleep.

heart rate, and oxygen saturation, attended by a technologist.

95806: Sleep study, unattended, simultaneous recording of heart rate, oxygen saturation, respiratory airflow, and respiratory effort.

G0399: Home sleep test with Type III portable monitor, unattended, minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation.

G0398: Home sleep study test with Type II portable monitor, unattended, minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort, and oxygen saturation.

5. The costs for these studies differ with sleep studies conducted in an office or lab (95811 and 95810, in particular) billed and reimbursed by government agencies and private insurance companies at rates three to four times that of at-home sleep studies (95806, in particular).

The Health Care Benefit Programs

The Medicare Program

6. The Medicare program ("Medicare") was established under Title XVIII of the Social Security Act. Medicare is a federal health care program providing benefits to persons who are sixty-five years of age or older or disabled. Medicare is administered by the Centers for Medicare and Medicaid Services ("CMS"), a federal agency under the United States Department of Health and Human Services (HHS). Medicare is a health care benefit program as defined by 18 U.S.C. § 24(b).

7. Medicare has four parts: hospital insurance (Part A), medical insurance (Part B), Medicare Advantage (Part C), and prescription drug benefits (Part D). Medicare Part B helps pay the cost of physician services, medical equipment and supplies, and other health services and

supplies not paid by Part A. Specifically, Medicare Part B covers medically necessary physician office services, diagnostic testing, and the ordering of Durable Medical Equipment (DME), such as CPAP machines and associated supplies.

The Medicaid Program

8. The Medicaid program ("Medicaid") is a state and federal funded health insurance program that provides health care benefits to certain individuals. It is a cooperative Federal/State program, which is managed by the states with federal funding. Medicaid helps to pay for reasonable and medically necessary services for individuals who are deemed eligible under State low-income programs. Medical services, diagnostic testing, and DME are among the types of reimbursable assistance available to Medicaid recipients. Medicaid is a "health care benefit program" as defined in 18 U.S.C. § 24(b). To become a participating health care provider in Medicare and/or Medicaid, a provider must voluntarily enroll and complete a provider agreement application for each program. These provider enrollment applications require that the provider certify that he or she is familiar with, and will follow, all Medicare and Medicaid laws, rules, and regulations.

9. To receive Medicare and/or Medicaid funds, enrolled providers, together with their authorized agents, employees, and contractors, are required to abide by all provisions of the Social Security Act, the regulations promulgated under the Act, and applicable policies, procedures, rules, and regulations issued by CMS and its authorized agents and contractors. Healthcare providers are provided with online access to Medicare manuals and services bulletins describing proper billing procedures and billing rules and regulations. Healthcare providers can only submit claims to Medicare and/or Medicaid for reasonable and medically necessary services that they actually rendered.

The Veterans Choice Program

10. The Veterans Health Administration (VHA) is the largest integrated health care system in the United States, providing care at 1,321 health care facilities, including 172 VA Medical Centers and 1,138 outpatient sites of care of varying complexity to over 9 million veterans enrolled in the Veterans Affairs (VA) health care program. VHA Medical Centers provide a wide range of services including traditional hospital-based services such as surgery, critical care, mental health, orthopedics, pharmacy, radiology, and physical therapy. In addition to direct VHA care, the VA also provides for veterans to receive care at community providers also known as community care. Such care can be funded via different mechanisms such as the VA Mission Act or the VA Choice Program.

11. The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 consolidated VA's community care programs into a new Veterans Community Care Program that helped ensure veterans choose VA by getting them the right care at the right time from the right provider. VA developed regulations to implement the new law, while also developing policies, training staff, and awarding contracts to furnish care.

12. VA created the Community Care Reimbursement System (CCRS), also known as the HealthShare Referral Manager (HSRM), as a network-based system where the community provider submits payment authorizations to the VA for community care provided.

13. The Veterans Choice Program (VCP) is one of several programs through which a veteran can receive care from a community provider, paid for by VA. For example, if a veteran needs an appointment for a specific type of care, and VA cannot provide the care in a timely manner or the nearest VA medical facility is too far away or too difficult to get to, then a veteran may be eligible for care through the VCP. To use the VCP, veterans must receive prior

authorization from VA to receive care from a provider that is part of VA's VCP network of community providers. The authorization is based on specific eligibility requirements and discussions with the veteran's VA provider. The VA must authorize care that is needed beyond the scope of the first authorization.

14. Founded in 1996, TriWest Healthcare Alliance (TriWest) is a private company contracted to help serve the healthcare needs of the nation's military and veteran communities. In 2013, TriWest was contracted as a Third-Party Administrator (TPA) to provide community care support to the Department of Veterans Affairs (VA). Since 2014, TriWest has supported the VA with coordinating community care healthcare in VA's Community Care Network (CCN) Regions 4 and 5; this includes Oregon, California, and Washington State. Community care is care provided to veterans at a private community-based clinic or provider that participates in the CCN managed by TriWest. TriWest provides credentialing and billings services to VA, which includes the credentialing providers in the CCN, processing healthcare claims, analysis of the claims, and reimbursement of the claims to the providers.

15. In particular, the process for veterans receiving community-based care funded by VA consist of the following: (1) VA either issues a referral for a veteran to a community provider or receives a referral request from a community provider (2) VA approves the request and issues an authorization, VA Form 10-7080, to the provider for services (3) TriWest receives a claim from provider for services provided (4) TriWest analyzes the claim and (5) TriWest partners with PGBA to process and pay out claims to CCN providers who have rendered services to veterans in accordance with an authorized VA referral. Further, as part of the authorization process, VA provides community care providers with details of reimbursable care via Nationally Standardized Episodes of Care (SEOC). The SEOC established national standards for care

which include CPT codes for potential implementation and reimbursement. Additionally, For CCN, TriWest follows Medicare billing guidelines, fee schedules and payment methodology when applicable. TriWest has designated PGBA as the claims payer for all authorized claims Providers will submit all claims to PGBA either through the electronic claims submission process, or via a paper claim form. All CCN claims process electronically, regardless of the method of submission.

OBJECT OF THE CONSPIRACY

16. Beginning on or around January 1, 2021, and continuing through to the present, in the District of Oregon and elsewhere, defendant GERAMI knowingly and intentionally combined, conspired, and agreed to execute a scheme and artifice to defraud as to material matters a health care benefit program affecting commerce, that is, Medicare, Medicaid, and the Veterans Choice Program and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, and the concealment of material facts, 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.

MANNER AND MEANS

17. The object of the conspiracy was carried out, in substance, as follows:

a. GERAMI, or other employees of CDTG at the direction of GERAMI, would submit fraudulent claims to HHS, the VHA, and private insurance companies for sleep tests allegedly conducted in office when, in fact, they were conducted either at home or not at all.

b. CDTG would overcharge insured patients using inappropriate billing codes for these tests.

c. GERAMI would submit, or cause CDTG and CD staff to submit claims via CMS 1500 forms, which were false, fictitious and fraudulent in that the claims sought reimbursement based on inflated services.

d. GERAMI would submit, or cause CDTG and CD staff, claims using CPT codes 95810 and 95811, knowing that the claims were incorrect and caused a higher reimbursement rate than was warranted.

e. Based on GERAMI's false and fraudulent claims, HHS and the VHA would reimburse CDTG and CD in amounts significantly higher than they were entitled to receive.

In violation of Title 18, United States Code, Section 1349.

FORFEITURE ALLEGATION

Upon conviction of the offense alleged in Count One of the Information, the Defendant, MERHDAD GERAMI, shall forfeit to the United States, pursuant to 18 U.S.C. § 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 including, but not limited to, a money judgment of $3,756,105.31, representing the amount of proceeds defendant obtained as a result of the offense.

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 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; it is the intent of the United States, pursuant to 21 U.S.C. § 853(p) as incorporated by 18 U.S.C. § 982(b), to seek forfeiture of any other property of said defendant(s) up to the value of the forfeitable property described above

Dated: June 22, 2026.

Respectfully submitted,

SCOTT E. BRADFORD
United States Attorney

/s/ Joseph H. Huynh
JOSEPH H. HUYNH
Assistant United States Attorney