UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF VERMONT

UNITED STATES OF AMERICA	)	
	)	
v.	)	**Criminal No.**
	)	2:26-cr-57-1
TAINA MOORE,	)	
	)	
Defendant.	)	
	)	
	)	

INFORMATION

The United States of America charges:

GENERAL ALLEGATIONS

At all times material to this Information:

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 provider 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.

Medicare Part B

8. 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.

9. 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 ...).

10. CMS Form 855 contained additional certifications that the provider would "not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare," and would "not submit claims with deliberate ignorance or reckless disregard of their truth or falsity."

11. 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

12. 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.

The Defendant and Relevant Entity and Individuals

13. Med Dept Inc. ("Med Dept") was a company formed under the laws of Florida. Med Dept was a DME provider operating nationwide with its principal place of business in Pompano Beach, Florida. Med Dept was an enrolled provider with Medicare.

14. **TANIA MOORE**, a resident of Miami, Florida, incorporated Med Dept and was identified as its sole owner and managing employee.

15. Entity 1 was an entity **MOORE** paid to induce the referral of Medicare beneficiaries to Med Dept.

16. Entity 2 was an entity **MOORE** paid to induce the referral of Medicare beneficiaries to Med Dept.

COUNT 1
Conspiracy to Pay Health Care Kickbacks
(18 U.S.C. § 371)

17. Paragraphs 1 through 16 of this Information are realleged and incorporated by reference as though fully set forth herein.

18. Beginning at least in or around September 2022, and continuing through at least in or around April 2025, in the District of Vermont and elsewhere, the defendant, **TANIA MOORE**, together with others, did knowingly and willfully combine, conspire, confederate, and agree with others to offer and pay kickbacks, directly and indirectly, overtly and covertly, to persons,

including persons at Entities 1, 2, and others, to induce such persons to refer Medicare beneficiaries to Med Dept. for the furnishing of and arranging for the furnishing of DME for which payment may be made in whole and in part under Medicare, contrary to Title 42, United States Code, Section 1320a-7b(b)(2).

19. In total, from February 2023 to August 2025, **TAINA MOORE**, through Med Dept, billed Medicare approximately $8.7 million in claims procured through the payment of kickbacks, and Medicare paid approximately $3.2 million for those claims.

20. In furtherance of the conspiracy and to effect its objects, within the District of Vermont and elsewhere, the defendant, **TANIA MOORE**, together with others, committed and caused to be committed, among others, the following:

Overt Acts

a. On or about December 1, 2023, Med Dept, directed by **MOORE**, billed Medicare $2,641.43 for a right hip orthosis for E.G., a Medicare beneficiary residing in Orleans, Vermont. The claim was induced by a kickback paid to Entity 1.

b. On or about January 25, 2024, Med Dept, directed by **MOORE**, billed Medicare $3,077.65 for a hip orthosis for C.T., a Medicare beneficiary residing in Burlington, Vermont. The claim was induced by a kickback paid to Entity 2.

All in violation of Title 18, United States Code, Sections 371 and 3551 et seq.

NOTICE OF FORFEITURE

21. The United States hereby gives notice to the defendant that, upon her conviction of the offense in Count One, the government will seek forfeiture in accordance with Title 18, United

States Code, Section 982(a)(7), which requires any person convicted of such offense to forfeit any property, real or personal, which constitutes or is derived, directly or indirectly, from gross proceeds traceable to such offense.

22. The property to be forfeited includes, but is not limited to, an order of forfeiture in the amount of $3,231,903.10, which represents the proceeds the defendant received as a result of the offense.

23. 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 that cannot be subdivided without difficulty,

it is the intent of the United States, pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b)(1), to seek forfeiture of any other

property of the defendant up to the value of the forfeitable property described in this forfeiture allegation.

UNITED STATES OF AMERICA, by

LORINDA LARYEA
CHIEF, FRAUD SECTION

Joshua L. Rankin
For

SARAH W. ROCHA
TRIAL ATTORNEY
FRAUD SECTION, CRIMINAL DIVISION
U.S. DEPARTMENT OF JUSTICE