UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 19-80168

18 U.S.C. § 1349
18 U.S.C. § 371
18 U.S.C. § 1347
42 U.S.C. § 1320a-7b(b)(2)(B)
18 U.S.C. § 2
18 U.S.C. § 982

CR-ROSENBERG/
Reinhart

UNITED STATES OF AMERICA

v.

JORDAN KARLICK,
MICHAEL MORANZ, and
JORDAN CHIBNICK,

Defendants.
_____/

INDICTMENT

The Grand Jury charges that:

GENERAL ALLEGATIONS

At all times material to this Indictment:

The 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, through its agency, the Centers for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare. Individuals who received benefits under Medicare were commonly referred to as Medicare "beneficiaries."

2. Medicare was subdivided into multiple program "parts." Medicare Part A covered health services provided by hospitals, skilled nursing facilities, hospices, and home health agencies. Medicare Part B covered physician services and outpatient care, including an individual's access to durable medical equipment ("DME"), such as orthotic devices and wheelchairs. Medicare Part C, also known as the "Medicare Advantage" Program, provided Medicare beneficiaries with the option to receive their Medicare benefits through private managed care plans, including health maintenance organizations and preferred provider organizations.

3. Medicare and Medicare Advantage were "health care benefit program[s]," as defined by Title 18, United States Code, Section 24(b), and "Federal health care program[s]" as defined by Title 42, United States Code, Section 1320a-7b(f).

Part C - Medicare Advantage

4. Medicare beneficiaries enrolled in Medicare Advantage plans with all of the same services provided by an original fee-for-service Medicare plan, in addition to mandatory supplemental benefits and optional supplemental benefits.

5. To receive Medicare Advantage benefits, a beneficiary was required to enroll in a managed care plan operated by a private company approved by Medicare. Those companies were often referred to as Medicare Advantage plan "sponsors." A beneficiary's enrollment in a Medicare Advantage plan was voluntary.

6. Rather than reimbursing based on the extent of the services provided, as CMS did for providers enrolled in original fee-for-service Medicare, CMS made fixed, monthly payments to a plan sponsor for each Medicare beneficiary enrolled in one of the sponsor's plans, regardless of the services rendered to the beneficiary that month or the cost of covering the beneficiary's

health benefits that month. The private health insurance companies then reimbursed the provider based on the services that were purportedly provided.

7. Medicare beneficiaries chose to enroll in a managed care plan administered by private health insurance companies, health maintenance organizations, or preferred provider organizations. A number of entities were contracted by CMS to provide managed care to Medicare beneficiaries through various approved plans. Such plans covered DME and related health care benefits, items, and services. Among its responsibilities, these Medicare Advantage plans received, adjudicated, and paid the claims of authorized providers seeking reimbursements for the cost of DME and related health care benefits, items, or services supplied to Medicare beneficiaries.

Durable Medical Equipment

8. Orthotic devices were a type of DME that included rigid and semi-rigid devices, such as knee braces, back braces, shoulder braces, and wrist braces (collectively, "braces").

9. DME companies, physicians, and other healthcare providers that provided services to Medicare beneficiaries were referred to as Medicare "providers." To participate in Medicare, providers were required to submit an application in which the providers agreed to comply with all Medicare-related laws and regulations. If Medicare approved a provider's application, Medicare assigned the provider a Medicare "provider number." A healthcare provider with a Medicare provider number could file claims with Medicare to obtain reimbursement for services rendered to beneficiaries.

10. Enrolled Medicare providers agreed to abide by the policies and procedures, rules, and regulations governing reimbursement. To receive Medicare funds, enrolled providers were required to abide by the Anti-Kickback Statute and other laws and regulations. Providers were

given access to Medicare manuals and services bulletins describing billing procedures, rules, and regulations.

11. Medicare reimbursed DME companies and other healthcare providers for items and services rendered to beneficiaries. To receive payment from Medicare, providers submitted or caused the submission of claims to Medicare electronically, either directly or through a billing company.

12. A Medicare claim for DME reimbursement was required to set forth, among other things, the beneficiary's name and unique Medicare identification number, the DME provided to the beneficiary, the date the DME was provided, the cost of the DME, and the name and unique physician identification number of the physician who prescribed or ordered the equipment.

13. 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 medical professional.

The Defendants and Related Entities

14. Medical Equipment Solutions of Southeast Florida ("MESS") was a Florida company that did business in Palm Beach County. MESS was a DME company that purportedly provided braces to patients including Medicare and Medicare Advantage plan beneficiaries.

15. Parris Medical Services, Inc. ("Parris") was a Florida corporation that did business in Palm Beach County. Parris was a DME company that purportedly provided braces to patients including Medicare and Medicare Advantage plan beneficiaries.

16. Mountain Home Care Equipment, Inc. ("Mountain") was a Florida corporation that did business in Palm Beach County. Mountain was a DME company that purportedly provided braces to patients including Medicare and Medicare Advantage plan beneficiaries.

17. Company A and Company B were call centers based in the Philippines.

18. Defendant **JORDAN KARLICK** was a resident of Palm Beach County, an owner, director, and manager of Parris, and the owner of Mountain.

19. Defendant **MICHAEL MORANZ** was a resident of Palm Beach County, an owner and director of Parris, and an owner of Mountain.

20. Defendant **JORDAN CHIBNICK** was a resident of Broward County, a manager of MESS, and an owner and director of Parris and Mountain.

21. Person A was the owner of Company A and Company B.

22. Individual 1 was an employee of a call center operating in India.

COUNT 1
Conspiracy to Commit Healthcare Fraud and Wire Fraud
(18 U.S.C. § 1349)

1. The General Allegations section of this Indictment is re-alleged and incorporated by reference as though fully set forth herein.

2. From in or around April 2015, through in or around April 2019, in Palm Beach County, in the Southern District of Florida, and elsewhere, the defendants,

JORDAN KARLICK,
MICHAEL MORANZ, and
JORDAN CHIBNICK,

did willfully, that is, with the intent to further the objects of the conspiracy, and knowingly, combine, conspire, confederate and agree with each other, Person A, Individual 1, and others known and unknown to the Grand Jury, to commit certain offenses against the United States, that is:

a. to knowingly and willfully 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 Medicare Advantage, 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 programs, in connection with the delivery of and payment for health care benefits, items, and services, in violation of Title 18, United States Code, 1347; and

b. to knowingly and with the intent to defraud, devise and intend to devise a scheme and artifice to defraud, and for obtaining money and property by means of materially false and fraudulent pretenses, representations and promises, knowing that the pretenses, representations, and promises were false and fraudulent when made, and for the purpose of executing such scheme and artifice did knowingly transmit and cause to be transmitted, by means of wire communication in interstate and foreign commerce, writings, signs, signals, pictures, and sounds, in violation of Title 18, United States Code, Section 1343.

Purpose of the Conspiracy

3. It was a purpose of the conspiracy for **JORDAN KARLICK**, **MICHAEL MORANZ**, **JORDAN CHIBNICK**, and their co-conspirators to unlawfully enrich themselves by, among other things: (a) offering and paying kickbacks and bribes in exchange for signed doctor's orders for Medicare and Medicare Advantage plan beneficiaries for braces; (b) submitting and causing the submission of false and fraudulent claims to Medicare and Medicare Advantage for braces that were medically unnecessary, ineligible for Medicare reimbursement, and/or not provided as represented; (c) concealing and causing the concealment of kickbacks and bribes and false and fraudulent claims; and (d) diverting fraud proceeds for their personal use and benefit, the use and benefit of others, and to further the fraud.

Manner and Means

The manner and means by which the defendants and their co-conspirators sought to accomplish the objects and purpose of the conspiracy included, among others, the following:

4. **JORDAN KARLICK, MICHAEL MORANZ,** and **JORDAN CHIBNICK** owned and operated MESS, Parris, and Mountain.

5. **JORDAN KARLICK** certified to Medicare that MESS would comply with all Medicare rules and regulations, including that he and MESS would refrain from violating the federal Anti-Kickback statute.

6. **JORDAN CHIBNICK** certified to Medicare that Mountain would comply with all Medicare rules and regulations, including that he and Mountain would refrain from violating the federal Anti-Kickback Statute.

7. **JORDAN KARLICK** and **MICHAEL MORANZ** certified to Medicare that Parris would comply with all Medicare rules and regulations, including that they and Parris would refrain from violating the federal Anti-Kickback Statute.

8. **JORDAN KARLICK, MICHAEL MORANZ,** and **JORDAN CHIBNICK** paid kickbacks and bribes to Person A, Individual 1, and others in exchange for signed prescriptions and other Medicare-required documents (collectively referred to as "doctors' orders") for medically unnecessary DME.

9. **JORDAN KARLICK, MICHAEL MORANZ, JORDAN CHIBNICK,** and others disguised the nature and source of these kickbacks and bribes by designating payments as "marketing" or "business process outsourcing," entering into sham contracts, and generating or causing the generation of fraudulent invoices.

10. **JORDAN KARLICK, MICHAEL MORANZ,** and **JORDAN CHIBNICK** provided, and caused the provision of, DME to beneficiaries that was medically unnecessary, did not fit, and that the beneficiaries often did not request.

11. **JORDAN KARLICK, MICHAEL MORANZ,** and **JORDAN CHIBNICK** used doctors' orders procured through the payment of bribes and kickbacks to submit and cause the submission of, approximately $23,998,993 in false and fraudulent claims, through interstate wire communication, to Medicare.

12. **JORDAN KARLICK, MICHAEL MORANZ, JORDAN CHIBNICK**, and others prevented beneficiaries from returning unwanted and medically unnecessary DME, so that **KARLICK, MORANZ,** and **CHIBNICK** could continue to bill and retain reimbursement for that DME.

13. As a result of these false and fraudulent claims, Medicare paid MESS, Parris, and Mountain approximately $9,883,261.

All in violation of Title 18, United States Code, Section 1349.

COUNT 2
Conspiracy to Defraud the United States and Pay Health Care Kickbacks (18 U.S.C. § 371)

1. The General Allegations section of this Indictment is re-alleged and incorporated by reference as though fully set forth herein.

2. From in or around April 2015, through in or around April 2019, in Palm Beach County, in the Southern District of Florida, and elsewhere, the defendants,

JORDAN KARLICK,
MICHAEL MORANZ, and
JORDAN CHIBNICK,

did willfully, that is, with the intent to further the objects of the conspiracy, and knowingly,

combine, conspire, confederate and agree with each other, and others known and unknown to the Grand Jury,

a. to defraud the United States by impairing, impeding, obstructing and defeating through deceitful and dishonest means, the lawful government functions of the United States Department of Health and Human Services in its administration and oversight of Medicare and Medicare Advantage plans, in violation of Title 18, United States Code Section 371, and to commit certain offenses against the United States, that is:

b. to violate Title 42, United States Code, Section 1320a-7b(b)(2)(B), by knowingly and willfully offering and paying remuneration, including kickbacks and bribes, directly and indirectly, overtly and covertly, to a person to induce such person to order or arrange for or recommend ordering any good, service, or item for which payment may be made in whole or in part under a Federal health care program, that is, Medicare and Medicare Advantage.

Purpose of the Conspiracy

3. It was a purpose of the conspiracy for **JORDAN KARLICK**, **MICHAEL MORANZ**, **JORDAN CHIBNICK**, and their co-conspirators, to unlawfully enrich themselves by: (a) offering and paying kickbacks and bribes in exchange for signed doctor's orders for Medicare and Medicare Advantage plan beneficiaries for braces; (b) submitting and causing the submission of claims to Medicare and Medicare Advantage for braces that were medically unnecessary, ineligible for Medicare and Medicare Advantage reimbursement, and/or not provided as represented; (c) concealing and causing the concealment of kickbacks and bribes; and (d) 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

The Manner and Means section of Count 1 is hereby re-alleged and incorporated as though fully set forth herein as a description of the Manner and Means of the conspiracy.

Overt Acts

In furtherance of the conspiracy, and to accomplish its objects and purpose, at least one co-conspirator committed and caused to be committed in the Southern District of Florida, and elsewhere, one of the following overt acts, among others:

1. On or about August 5, 2015, **JORDAN KARLICK** signed a Business Process Outsourcing Agreement and a Marketing Services Agreement with Company A and Company B which falsely described that Company A and Company B would provide "business process outsourcing" and "marketing" services to MESS.

2. On or about February 11, 2016, **JORDAN CHIBNICK** sent an email to **JORDAN KARLICK** and **MICHAEL MORANZ** attaching a spreadsheet that tracked kickback payments made and doctors' orders received.

3. On or about February 29, 2016, **JORDAN KARLICK** sent an email to an employee of Company A, listing "key words" that "need to be on the Dr notes," and offering to "pay more money" for doctors' orders containing these key words.

4. On or about March 15, 2015, the Medicare billing coordinator for Parris and Mountain emailed **JORDAN KARLICK, MICHAEL MORANZ,** and **JORDAN CHIBNICK** that doctors' orders recently purchased from Company A and Company B "in no way meet [Medicare] coverage requirements."

5. On or about March 15, 2015, **JORDAN KARLICK** replied by email that he did not believe it would be possible to obtain better doctors' notes, so to submit claims using the existing notes.

6. On or about July 15, 2016, **JORDAN KARLICK** signed a Business Process Outsourcing Agreement and a Marketing Services Agreement with Company A and Company B which falsely described that Company A and Company B would provide "business process outsourcing" and "marketing" services to Parris.

7. On or about February 20, 2017, **JORDAN KARLICK** emailed Person A, copying **MICHAEL MORANZ**, that Medicare contractor Noridian had denied "7 out of the last 10" Parris claims "due to bad notes. Noridian is saying that the notes are not sufficient enough and don't go into enough details. So we need to change the template. We to add more info to the notes and make them more cumbersome and detailed."

8. On or about February 28, 2017, **JORDAN KARLICK** emailed Person A, stating, "I have thoughts and ideas after speaking to Noridian, we need to make sure that the tele med company will make the changes. . . . Medications we need to make sure we label their current medications even if they are not for pain and if none should put Tylenol or something."

9. On or about July 18, 2017, **MICHAEL MORANZ** sent an email to Individual 1 noting that Parris was owed $4,000 worth of doctors' orders purchased through kickbacks.

10. On or about August 10, 2018, **JORDAN CHIBNICK** signed a Business Process Outsourcing Agreement and a Marketing Services Agreement with Company A and Company B which falsely described that Company A and Company B would provide "business process outsourcing" and "marketing" services to Mountain.

11. On or about January 4, 2019, **JORDAN CHIBNICK** wired two payments in the amount of $20,904 and $31,500 to Company A and Company B in payment for doctors' orders for DME.

All in violation of Title 18, United States Code, Section 371.

COUNTS 3-6
Health Care Fraud
(18 U.S.C. § 1347)

1. The General Allegations section of this Indictment is re-alleged and incorporated by reference as though fully set forth herein.

2. From on or about April 2015, through in or around April 2019, in Palm Beach County, in the Southern District of Florida, and elsewhere, the defendants,

JORDAN KARLICK,
MICHAEL MORANZ, and
JORDAN CHIBNICK,

in connection with the delivery and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud a health care benefit program affecting commerce, as defined by Title 18, United States Code, Section 24(b), that is, Medicare and Medicare Advantage, 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.

Purpose of the Scheme and Artifice

3. It was a purpose of the scheme and artifice for **JORDAN KARLICK, MICHAEL MORANZ, JORDAN CHIBNICK**, and their accomplices to unlawfully enrich themselves by: (a) offering and paying kickbacks and bribes in exchange for signed doctor's orders for Medicare and Medicare Advantage plan beneficiaries for braces; (b) submitting and causing the submission

of false and fraudulent claims to Medicare and Medicare Advantage for braces that were medically unnecessary, ineligible for Medicare and Medicare Advantage reimbursement, and/or not provided as represented; (c) concealing and causing the concealment of kickbacks and bribes and false and fraudulent claims; and (d) diverting fraud proceeds for their personal use and benefit, the use and benefit of others, and to further the fraud.

The Scheme and Artifice

4. The allegations contained in the Manner and Means Section of Count 1 are re-alleged and incorporated by reference as though fully set forth herein as a description of the Scheme and Artifice.

Acts in Execution or Attempted Execution of the Scheme and Artifice

1. On or about the dates set forth as to each count below, in Palm Bach County, in the Southern District of Florida, and elsewhere, **JORDAN KARLICK, MICHAEL MORANZ,** and **JORDAN CHIBNICK,** in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, the above-described scheme and artifice to defraud a health care benefit program affecting commerce, that is Medicare and Medicare Advantage, 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 programs, in that the defendants submitted and caused the

submission of false and fraudulent claims seeking the identified dollar amounts, representing that Parris and Mountain provided DME to Medicare beneficiaries pursuant to doctors' orders:

Count	Date	Billing Entity	Beneficiary	Amount Billed	Product Code; Claim Number
3	10/26/2018	Parris	M.N.	$1,000	L3960 118303806579000
4	11/6/2018	Mountain	R.H.	$1,500	L0656; 118340803190000
5	11/8/2018	Mountain	R.H.	$995	L3916 118340803193000
6	12/7/2018	Mountain	R.B.	$1,000	L0650 119009804207000

In violation of Title 18, United States Code, Sections 1347 and 2.

COUNTS 7-9
Payment of Kickbacks in Connection with a Federal Health Care Program
(42 U.S.C. § 1320a-7b(b)(2)(B))

5. The General Allegations section of this Indictment is re-alleged and incorporated by reference as though fully set forth herein.

6. On or about the dates set forth below, in Palm Beach County, in the Southern District of Florida, and elsewhere, the defendants,

JORDAN KARLICK,
MICHAEL MORANZ, and
JORDAN CHIBNICK,

did knowingly and willfully offer and pay remuneration, including kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, to a person to induce such person to order or arrange for or recommend ordering any good, service, or item for which payment may be made in whole or in part under a Federal health care program, that is, Medicare and Medicare Advantage:

Count	Approximate Date	Approximate Kickback Amount
7	3/8/2017	$28,080
8	3/17/2017	$28,080
9	4/11/2017	$28,080

In violation of Title 42, United States Code, Section 1320a-7b(b)(2)(B), and Title 18, United States Code, Section 2.

FORFEITURE
(18 U.S.C. § 982)

1. The allegations contained in this Indictment are re-alleged and incorporated by reference as though fully set forth herein for the purpose of alleging forfeiture to the United States of certain property in which the defendants have an interest.

2. Upon conviction of any violation as alleged in Counts 1 through 9 of this Indictment, the defendants so convicted shall forfeit to the United States, pursuant to Title 18, United States Code, Section 982(a)(7), any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of such violation.

3. The property subject to forfeiture, pursuant to Title 18, United States Code, Section 982(a)(7), includes, but is not limited to, approximately $9,883,261, which constitutes the sum equal in value to the gross proceeds traceable to the commission of the health care violations alleged in this Indictment.

4. If any of the property described above, as a result of any act or omission of the defendants:

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 co-mingled with other property which cannot be divided without difficulty,

the United States shall be entitled to forfeiture of substitute property, pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b)(1).

All pursuant to Title 18, United States Code, Section 982(a)(7), and the procedures set forth in Title 21, United States Code, Section 853, made applicable by Title 18, United States Code Section 982(b)(1).

A TRUE BILL

FOREPERSON

ARIANA FAJARDO ORSHAN
UNITED STATES ATTORNEY
SOUTHERN DISTRICT OF FLORIDA

ALLAN MEDINA
ACTING DEPUTY CHIEF
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE

SARA CLINGAN
CATHERINE WAGNER
TRIAL ATTORNEYS
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE