2019R00875/HALVERSON

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA	:	Hon.
	:	
v.	:	Crim. No. 20-
	:	
CORNELIUS O'LEARY	:	18 U.S.C. § 1349
	:	

INFORMATION

The defendant having waived in open court prosecution by indictment, the Attorney for the United States, acting under authority conferred by 28 U.S.C. § 515, for the District of New Jersey charges:

1. At all times relevant to this Information:

Individuals and Entities

a. Defendant CORNELIUS O'LEARY was a United States citizen who resided in Charlotte, North Carolina. CORNELIUS O'LEARY was a medical doctor licensed to practice in New York and California, and served as a telemedicine doctor at multiple purported telemedicine companies, including, but not limited to, AffordADoc, as described below. CORNELIUS O'LEARY worked as an independent contractor for the telemedicine companies.

b. Creaghan Harry, a co-conspirator not charged in this Information, was a United States citizen who resided in Highland Beach, Florida.

c. Lester Stockett, a co-conspirator not charged in this Information, was a United States citizen who resided in the country of Colombia.

d. Creaghan Harry and Lester Stockett owned and operated a purported telemedicine company, Telemed Health Network LLC (dba "AffordADoc"). AffordADoc was a Delaware Limited Liability Company, with its principal office in Boca Raton, Florida, doing business throughout the United States.

The Medicare Program

e. The Medicare Program ("Medicare") was a federal health care program providing benefits to persons who were 65 years or older, or disabled. Medicare was administered by the Centers for Medicare and Medicaid Services ("CMS"), a federal agency under the United States Department of Health and Human Services. Individuals who received Medicare benefits were referred to as Medicare beneficiaries.

f. Medicare was a "Federal health care program" as defined in Title 42, United States Code, Section 1320a-7b(f), and a "health care benefit program" as defined in Title 18, United States Code, Section 24(b).

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

h. Specifically, Medicare Part B covered medically necessary physician office services and outpatient care, including the ordering of durable medical equipment, prosthetics, orthotics, and supplies, such as Off-The-Shelf ("OTS") ankle braces, knee braces, back braces, elbow braces, wrist braces, and hand braces (collectively "braces"). OTS braces required minimal self-

adjustment for appropriate use and did not require expertise in trimming, bending, molding, assembling, or customizing to fit to the individual.

i. CMS contracted with various companies to receive, adjudicate, process, and pay Part B claims, including claims for braces. CMS also contracted with the Program Safeguard Contractor, or ZPIC, which were contractors that investigated fraud, waste, and abuse. As part of an investigation, the Program Safeguard Contractor or ZPIC might conduct a clinical review of medical records to ensure that payment was made only for services that met all Medicare coverage and medical necessity requirements.

j. Brace 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 abide by the policies and procedures, rules, and regulations governing reimbursement. To receive Medicare funds, enrolled providers, together with their authorized agents, employees, and contractors, were 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. Health care providers were given and provided with online access to Medicare manuals and services bulletins describing proper billing procedures and billing rules and regulations.

k. If Medicare approved a provider's application, Medicare assigned the provider a Medicare Provider Identification Number ("PIN" or

"provider number"). A health care provider who was assigned a Medicare PIN and provided services to beneficiaries was able to submit claims for reimbursement to the Medicare contractor/carrier that included the PIN assigned to that medical provider. Payments under the Medicare program were often made directly to a provider of the goods or services, rather than to a Medicare beneficiary. This payment occurred when the provider submitted the claim to Medicare for payment, either directly or through a billing company.

l. Under Medicare Part B, claims for braces were required to be reasonable and medically necessary for the treatment or diagnosis of the patient's illness or injury. Medicare used the term "ordering/referring" provider to identify the physician or nurse practitioner who ordered, referred, or certified an item or service reported in that claim. Individuals ordering or referring these services were required to have the appropriate training, qualifications, and licenses to provide such services. A Medicare claim was required to set forth, among other things, the beneficiary's name, the date the services were provided, the cost of the services, the name and identification number of the physician or other health care provider who had ordered the services, and the name and identification number of the brace provider that had provided the services. Providers conveyed this information to Medicare by submitting claims using billing codes and modifiers.

m. To be reimbursed from Medicare for braces, the items or services had to be reasonable, medically necessary, appropriately documented,

and actually provided as represented to Medicare. Medicare would not pay claims procured through kickbacks and bribes.

n. Medicare regulations required health care providers enrolled with Medicare to maintain complete and accurate patient medical records reflecting the medical assessment and diagnoses of their patients, as well as records documenting actual treatment of the patients to whom services were provided and for whom claims for payment were submitted by the physician. Medicare required complete and accurate patient medical records so that Medicare would be able to verify that the services were provided as described on the claim form. These records were required to be sufficient to permit Medicare, through its contractors, to review the appropriateness of Medicare payments made to the health care provider.

o. According to Local Coverage Determination ("LCD") for Knee Orthoses (L33318), which was adopted nationally for services performed on or after October 1, 2015, knee braces, including L1381, L1386, L1832, L1833, L1843, L1845, L1850, L1851, and L1852, required an in-person examination of the patient. The LCD stated that knee braces were medically necessary only where knee instability was documented by an in-person examination of the beneficiary and objective description of joint laxity (e.g., varus/valgus instability, anterior/posterior Drawer test). Claims were not deemed reasonable and necessary if only pain or a subjective description of joint instability was documented.

p. According to the Local Coverage Determination for Back Orthoses (LCD L33790), which was adopted nationally for services performed on or after October 1, 2015, back braces (L0450–L0651) were covered by Medicare only when they were ordered: (1) to reduce pain by restricting mobility of the trunk; (2) to facilitate healing following an injury to the spine or related soft tissues; (3) to facilitate healing following a surgical procedure on the spine or related soft tissue; or (4) to otherwise support weak spinal muscles and/or a deformed spine.

Telemedicine

q. Telemedicine provided a means of connecting patients to doctors by using telecommunications technology, such as the internet or the telephone, to interact with a patient.

r. Telemedicine companies provided telemedicine services to individuals by hiring doctors and other health care providers. Telemedicine companies typically paid doctors a fee to conduct consultations with patients. In order to generate revenue, telemedicine companies typically either billed insurance or offered a membership program to customers.

s. Medicare Part B covered expenses for specified telehealth services if certain requirements were met. These requirements included that (i) the beneficiary was located in a rural or health professional shortage area; (ii) services were delivered via an interactive audio and video telecommunications system; and (iii) the beneficiary was at a practitioner's office or a specified

medical facility – not at a beneficiary's home – during the telehealth consultation with a remote practitioner.

t. Medicare regulations regarding telehealth concerned payment for telehealth consultation services only and did not prohibit ordering DME where the consultation itself was not billed to Medicare. However, some Medicare contractors took the position that the failure to comply with these requirements could inform their determination of medical necessity for DME ordered.

u. Telemedicine membership programs generated revenue for telemedicine companies from customers who: (i) signed a contract with the telemedicine company; (ii) paid a set dollar amount per month, and (iii) paid a set dollar amount each time the customer has an encounter with a physician.

COUNT ONE
(Conspiracy to Commit Health Care Fraud)

2. The allegations set forth in paragraph 1 of the Information are re-alleged and incorporated herein.

3. From in or around November 2016 through on or about April 9, 2019, in the District of New Jersey, and elsewhere, the defendant,

CORNELIUS O'LEARY,

did intentionally and knowingly combine, conspire, confederate, and agree with Creaghan Harry, Lester Stockett, and others known and unknown, to knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud a health care benefit program, as that term is 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, any health care benefit program, in connection with the delivery of and payment for health care benefits, items, and services, contrary to Title 18, United States Code, Section 1347.

Goal of the Conspiracy

4. It was the goal of the conspiracy for defendant CORNELIUS O'LEARY, Creaghan Harry, Lester Stockett, and others to unlawfully enrich themselves by, among other things, (a) submitting and causing the submission of false and fraudulent claims to Medicare that were (i) procured through the payment of kickbacks and bribes, (ii) medically unnecessary, (iii) not eligible for Medicare reimbursement, and (iv) not provided as represented; (b) concealing the submission of false and fraudulent claims and the receipt and transfer of the proceeds from the fraud; and (c) diverting proceeds of the fraud for the personal use and benefit of the defendant and his co-conspirators.

Manner and Means of the Conspiracy

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

a. CORNELIUS O'LEARY certified to Medicare that he would comply with all Medicare rules and regulations, and federal laws, including that he would not knowingly present or cause to be presented a false and fraudulent claim for payment by Medicare and that he would comply with the Anti-Kickback Statute. Despite this certification, O'LEARY proceeded to authorize false and

fraudulent claims for reimbursement for DME through his work for his co-conspirators' telemedicine companies.

b. CORNELIUS O'LEARY gained access to Medicare beneficiary information for thousands of vulnerable Medicare beneficiaries from AffordADoc and other telemedicine companies, in order for CORNELIUS O'LEARY to sign brace orders for those beneficiaries.

c. Creaghan Harry, Lester Stockett, and others paid or caused payments to be made to CORNELIUS O'LEARY and others to sign brace orders and cause the submission of brace claims to Medicare regardless of medical necessity, in order to increase revenue for themselves and their coconspirators.

d. CORNELIUS O'LEARY ordered braces regardless of medical necessity, in the absence of a pre-existing doctor-patient relationship, without a physical examination, and frequently based solely on a short telephonic conversation with the beneficiary.

e. CORNELIUS O'LEARY, Creaghan Harry, Lester Stockett, and others falsified, fabricated, altered, and caused the falsification, fabrication, and alteration of patient files, brace orders, and other records, all to support claims to Medicare for braces that were obtained through illegal kickbacks and bribes, medically unnecessary, ineligible for Medicare reimbursement, and not provided as represented.

f. CORNELIUS O'LEARY, Creaghan Harry, Lester Stockett, and others concealed and disguised the scheme by preparing and causing to be prepared

false and fraudulent documentation, and submitting and causing the submission of false and fraudulent documentation to Medicare.

g. CORNELIUS O'LEARY, Creaghan Harry, Lester Stockett, and others submitted and caused the submission of false and fraudulent claims to Medicare in an amount in excess of approximately $18.8 million for braces that were procured through the payment of kickbacks and bribes, medically unnecessary, ineligible for Medicare reimbursement, and not provided as represented.

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

FORFEITURE ALLEGATIONS

(18 U.S.C. § 981(a)(1)(C) and 28 U.S.C. § 2461; 18 U.S.C. §§982(a)(1) and (7) – Criminal Forfeiture)

6. The allegations contained in this Information are re-alleged and incorporated by reference as though fully set forth herein for the purpose of alleging forfeiture against defendant,

CORNELIUS O'LEARY,

pursuant to Title 18, United States Code, Sections 981 and 982, and Title 28, United States Code, Section 2461.

7. Pursuant to Title 18, United States Code, Section 981(a)(1)(C), together with Title 28, United States Code, Section 2461, upon being convicted of the crime charged in this Information, the convicted defendant shall forfeit to the United States any property, real or personal, which constitutes or is derived from proceeds traceable to the commission of the offense.

8. Pursuant to Title 18, United States Code, Section 982(a)(7), upon being convicted of the crime charged in this Information, the convicted defendant

shall forfeit to the United States any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

Substitute Assets Provision

9. 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 person;

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 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), to seek forfeiture of any other property of defendant CORNELIUS O'LEARY up to the value of the forfeitable property described above.

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Acting Under Authority
Conferred By 28 U.S.C. § 515

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CASE NUMBER: _____

United States District Court
District of New Jersey

UNITED STATES OF AMERICA

v.

CORNELIUS O'LEARY

INFORMATION FOR
18 U.S.C. § 1349

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BY 28 U.S.C. § 515

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