UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

UNITED STATES OF AMERICA	Case No: 18-cr-20451
v.	Hon. Denise Page Hood
D-3 DAVID WEAVER	VIO: 18 U.S.C. § 1349
Defendant.	

_____/

SECOND SUPERSEDING INFORMATION

THE UNITED STATES OF AMERICA CHARGES:

General Allegations

At all times relevant to this Second Superseding Information:

The Medicare Program

1. The Medicare program was a federal health care program providing benefits to persons who were 65 years of age 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 benefits under Medicare were referred to as Medicare "beneficiaries."

2. Medicare was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b).

3. Medicare had four parts: hospital insurance (Part A), medical insurance (Part B), Medicare Advantage (Part C), and prescription drug benefits (Part D).

4. Specifically, Part A of the Medicare program covered inpatient hospital services, home health and hospice care, and skilled nursing and rehabilitation.

5. Part B of the Medicare program covered the cost of physicians' services, medical equipment and supplies, and diagnostic laboratory services. Specifically, Part B covered medically necessary physician office services, outpatient physical therapy services, nerve conduction testing, ultrasounds, and nerve block injections, including facet joint injections. Part B also covered services that were provided in connection with a laboratory testing facility, including urine drug testing.

6. National Government Services ("NGS") administered the Medicare Part A program for claims arising in the State of Michigan. Wisconsin Physicians Service ("WPS") administered the Medicare Part B program for claims arising in the State of Michigan. CGS Administrators LLC ("CGS") administered the Medicare Part B program for claims arising in the State of Ohio. CMS contracted with NGS to receive, adjudicate, process, and pay Part A claims. CMS contracted with WPS and CGS to receive, adjudicate, process, and pay certain Part B claims, including medical services related to physician office services, outpatient physical therapy services, and nerve block injections, including facet joint injections, as well as

services that were provided in connection with a laboratory testing facility, including urine drug testing.

7. TrustSolutions LLC was the Program Safeguard Contractor for Medicare Part A and Part B in the State of Michigan until April 24, 2012, when it was replaced by Cahaba Safeguard Administrators LLC as the Zone Program Integrity Contractor ("ZPIC"). Cahaba was replaced by AdvancedMed in May 2015.

8. The Program Safeguard Contractor or ZPIC was a contractor that investigated fraud, waste, and abuse. As part of an investigation, the Program Safeguard Contractor or ZPIC may have conducted a clinical review of medical records to ensure that payment was made only for services that met all Medicare coverage and medical necessity requirements.

9. 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.

10. Upon certification, the medical provider, whether a clinic, physician, or other health care provider that provided services to Medicare beneficiaries, was able to apply for a Medicare Provider Identification Number ("PIN") for billing purposes. In its enrollment application, a provider was required to disclose to Medicare any

person or company who held an ownership interest of 5% or more or who had managing control of the provider. 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.

11. 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, and the name and identification number of the physician or other health care provider who had ordered the services. When an individual medical provider was associated with a clinic and medically necessary services were provided at that clinic's location, Medicare Part B required that the individual provider numbers associated with the clinic be placed on the claim submitted to the Medicare contractor.

12. By becoming a participating provider in Medicare, enrolled 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.

13. Health care providers could only submit claims to Medicare for reasonable and medically necessary services that they rendered. Medicare would not pay claims procured through kickbacks and bribes.

14. 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 may verify that the services were provided as described on the claim form. These records were required to be sufficient to permit Medicare, through WPS and other contractors, to review the appropriateness of Medicare payments made to the health care provider.

15. Under Medicare Part B, physician office visit services, outpatient physical therapy services, nerve conduction, and nerve block injections, including facet joint injections, were required to be reasonable and medically necessary for the treatment or diagnosis of the patient's illness or injury. Individuals providing these services were required to have the appropriate training, qualifications, and licenses to provide such services. Providers were required to: (1) document the medical

necessity of these services; (2) document the date the service was performed; (3) identify the provider who performed the service; and (4) identify the clinic, physician office, or group practice where the provider provided the service. Providers conveyed this information to Medicare by submitting claims using billing codes and modifiers. To be reimbursed from Medicare for physician office visit services, outpatient physical therapy services, nerve conduction, and nerve block injections, including facet joint injections, the services had to be reasonable, medically necessary, documented, and actually provided as represented to Medicare. Providers were required to maintain patient records to verify that the services were provided as represented on the claim form to Medicare. When an individual medical provider was associated with a clinic, Medicare Part B required that the individual provider number associated with the clinic be placed on the claim submitted to the Medicare contractor.

16. Under Medicare Part B, for a laboratory to properly bill and be paid by Medicare for laboratory testing, including urine drug testing, it was required that the patient must have, among other things, qualified for the testing, including urine drug testing, under Medicare's established rules and regulations. The testing also was required to be rendered according to Medicare's rules and regulations, and certain documents must have been completed before a claim was submitted for reimbursement to Medicare.

17. For a laboratory to properly bill and be paid by Medicare for urine drug testing, the urine drug testing was required to be both reasonable and medically necessary. Urine screenings could be "qualitative" and used to determine the presence or absence of substances, or the screenings could be "quantitative" and used to provide a numerical concentration of a substance. Medicare limited the allowed purposes of quantitative screenings. One such accepted purpose would have been if a patient tested negative for a prescribed medication during a qualitative screening, but the patient insisted s/he was taking the medication. A laboratory may have then performed a quantitative screening to evaluate or confirm the findings of the qualitative testing. The same was true if a patient tested positive for a non-prescribed medication/drug during qualitative testing which s/he insisted had not been used. However, under Medicare rules and regulations, regular, routine, or recreational drug screenings, were not reasonable or medically necessary. Further, Medicare required that the patient's medical record include documentation that fully supported the reasonableness of and medical necessity for the urine drug testing.

18. To receive reimbursement for a covered service from Medicare, a provider was required to submit a claim, either electronically or using a form (*e.g.*, a CMS-1500 form or UB-92), containing the required information appropriately identifying the provider, patient, and services rendered, among other things.

The Patino Medical Practice

19. Renaissance Age Management Institute LLC ("RenAMI") was a Michigan corporation doing business at 29150 Buckingham Street, Ste. 6, Livonia, Michigan. RenAMI was enrolled as a participating provider with Medicare and submitted claims to Medicare.

The Patino Diagnostic Laboratories

20. FDRS Diagnostics, PLLC ("FDRS") was a Michigan corporation doing business at 29150 Buckingham Street, Ste. 6 #101, Livonia, Michigan. FDRS was enrolled as a participating provider with Medicare and submitted claims to Medicare.

21. Patino Laboratories, Inc. ("Patino Laboratories") (referred to, collectively with FDRS, as the "Patino Diagnostic Laboratories") was a Michigan corporation doing business at 29150 Buckingham Street, Ste. 8, Livonia, Michigan. Patino Laboratories was enrolled as a participating provider with Medicare and submitted claims to Medicare.

Defendant and Other Individuals

22. Defendant **DAVID WEAVER**, a resident of Farmington Hills, Michigan, was a physician licensed in the State of Michigan who was enrolled as a participating provider with Medicare for RenAMI.

23. Francisco Patino, a resident of Wayne County, was a practicing physician who was enrolled as a participating provider with Medicare and submitted

claims to Medicare. Francisco Patino controlled and operated RenAMI, FDRS, and Patino Laboratories, which were operated out of multiple suites at the same street address, 29150 Buckingham Street, Livonia, Michigan. Francisco Patino was the sole owner of RenAMI and a part owner of FDRS and Patino Laboratories.

COUNT 1
(18 U.S.C. § 1349—Conspiracy to Commit Health Care Fraud)
D-3 DAVID WEAVER

24. Paragraphs 1 through 23 of the General Allegations section of this Second Superseding Information are re-alleged and incorporated by reference as though fully set forth herein.

25. From in or around November 2013, and continuing through in or around December 2015, in Wayne County, in the Eastern District of Michigan, and elsewhere, **DAVID WEAVER** did willfully and knowingly, combine, conspire, confederate, and agree with Francisco Patino and others known and unknown, to commit certain offenses against the United States, namely: 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 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, 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.

Purpose of the Conspiracy

26. It was a purpose of the conspiracy for **DAVID WEAVER** and his co-conspirators to unlawfully enrich themselves by, among other things: (a) submitting and causing the submission of false and fraudulent claims to Medicare for claims based on kickbacks and bribes; (b) submitting and causing the submission of false and fraudulent claims to Medicare for services that were (i) medically unnecessary; (ii) not eligible for Medicare reimbursement; and (iii) not provided as represented; (c) concealing the submission of false and fraudulent claims to Medicare and the receipt and transfer of the proceeds from the fraud; and (d) diverting proceeds of the fraud for the personal use and benefit of the defendant and his co-conspirators.

Manner and Means

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

27. **DAVID WEAVER** falsely 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 refrain from violating the federal Anti-Kickback Statute.

28. **DAVID WEAVER**, Francisco Patino, and others would require vulnerable Medicare beneficiaries, including those addicted to opioids, to submit to expensive injections before prescribing opioids and other controlled substances, even though the injections were medically unnecessary, sometimes painful, not eligible for Medicare reimbursement, and not provided as represented.

29. **DAVID WEAVER**, Francisco Patino, and others referred and caused the referral of Medicare beneficiaries for urine drug testing and other testing to laboratories specified by Francisco Patino, including FDRS and Patino Laboratories, which were procured by the payment of kickbacks and bribes, medically unnecessary, not eligible for Medicare reimbursement, and not provided as represented.

30. **DAVID WEAVER**, Francisco Patino, and others falsified, fabricated, altered, and caused the falsification, fabrication, and alteration of medical records, including patient files, treatment plans, diagnostic testing orders, and other records, all to support claims for office visits, injections, urine drug testing, and other services that were obtained through illegal kickbacks and bribes, medically unnecessary, not eligible for Medicare reimbursement, and not provided as represented.

31. **DAVID WEAVER**, Francisco Patino, and others submitted and caused the submission of false and fraudulent claims to Medicare in an amount of approximately $1,845,779.04 that were obtained through illegal kickbacks and

bribes, medically unnecessary, not eligible for Medicare reimbursement, and not provided as represented.

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

32. The allegations contained in Count 1 of this Second Superseding Information are re-alleged and incorporated by reference as though fully set forth herein for the purpose of alleging forfeiture against defendant **DAVID WEAVER** pursuant to Title 18, United States Code, Sections 981 and 982, and Title 28, United States Code, Section 2461.

33. 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 Count 1 of this Second Superseding 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.

34. Pursuant to Title 18, United States Code, Section 982(a)(7), upon being convicted of the crime charged in Count 1 of this Second Superseding 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.

35. *Money Judgment*: The government shall also seek a money judgment

of at least $414,015, which represents the value of the property subject to forfeiture.

36. *Substitute Assets*: If the property described above as being subject to forfeiture, 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) and/or Title 28, United States Code, Section 2461, to seek to forfeit any other property of **DAVID WEAVER** up to the value of such property.

MATTHEW SCHNEIDER
UNITED STATES ATTORNEY

s/ALLAN MEDINA
ALLAN MEDINA
Chief, Health Care Fraud Unit
Criminal Division, Fraud Section
211 W. Fort St., Suite 2001
Detroit, MI 48226
(313) 226-9618
allan.medina@usdoj.gov

s/MALISA DUBAL
MALISA DUBAL
Assistant Chief
Criminal Division, Fraud Section
211 W. Fort St., Suite 2001
Detroit, MI 48226
(202) 660-2001
malisa.dubal@usdoj.gov

Trial Attorney
JACOB FOSTER
Assistant Chief
Criminal Division, Fraud Section
211 W. Fort St., Suite 2001
Detroit, MI 48226
(202) 957-2958
Kathleen.Cooperstein@usdoj.gov

United States District Court Eastern District of Michigan	**Criminal Case Cover Sheet**	**Case Number** 18-cr-20451

NOTE: It is the responsibility of the Assistant U.S. Attorney signing this form to complete it accurately in all respects.

Companion Case Information	**Companion Case Number:**
This may be a companion case based upon **LCrR 57.10 (b)(4)**[1]**:**	**Judge Assigned:**
☐ **Yes** ☒ **No**	**AUSA's Initials:**

Case Title: USA v. Patino

County where offense occurred : Oakland County, Wayne County

Check One: ☒**Felony** ☐**Misdemeanor** ☐**Petty**

____Indictment/____Information --- **no** prior complaint.
____Indictment/____Information --- based upon prior complaint [**Case number:**]
____Indictment/__✓__Information --- based upon **LCrR 57.10 (d)** ***[Complete Superseding section below]***.

Superseding Case Information

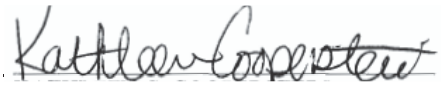
Superseding to Case No: 18-cr-20451 **Judge:** Denise Page Hood

☐ Corrects errors; no additional charges or defendants.
☐ Involves, for plea purposes, different charges or adds counts.
☒ Embraces same subject matter but adds the additional defendants or charges below:

Defendant name	**Charges**	**Prior Complaint (if applicable)**
DAVID WEAVER	18 U.S.C. § 1349	

Please take notice that the below listed Assistant United States Attorney is the attorney of record for the above captioned case.

July 21, 2020
Date



Kathleen Cooperstein,Trial Attorney
211 West Fort Street, Detroit, MI 48226
Phone:(202) 957-2958
Fax: (313) 226-0816
E-Mail address: Kathleen.Cooperstein@usdoj.gov
Attorney Bar #: VA 84262

[1] Companion cases are matters in which it appears that (1) substantially similar evidence will be offered at trial, or (2) the same or related parties are present, and the cases arise out of the same transaction or occurrence. Cases may be companion cases even though one of them may have already been terminated.