ORIGINAL

Approved: _____
TIMOTHY V. CAPOZZI
Assistant United States Attorney

Before: HONORABLE KEVIN NATHANIEL FOX
United States Magistrate Judge
Southern District of New York

18 MAG 5427

UNITED STATES OF AMERICA,	**SEALED COMPLAINT**
v.	Violations of 18 U.S.C. §§ 1349, 1347 and 2
ANTHONY PALMIERI,	
Defendant.	COUNTY OF OFFENSE: NEW YORK

SOUTHERN DISTRICT OF NEW YORK, ss.:

STEVEN KAY, being duly sworn, deposes and says that he is a Special Agent with the United States Department of Health and Human Services, Office of Inspector General ("HHS-OIG"), and charges as follows:

COUNT ONE
(Conspiracy to Commit Health Care Fraud)

1. From at least in or about November 2014 through at least in or about May 2016, in the Southern District of New York and elsewhere, ANTHONY PALMIERI, the defendant, and others known and unknown, willfully and knowingly, did combine, conspire, confederate, and agree together and with each other to commit health care fraud, in violation of Title 18, United States Code, Section 1347.

2. It was a part and object of the conspiracy that ANTHONY PALMIERI, the defendant, and others known and unknown, willfully and knowingly, would and did execute and attempt to execute a scheme and artifice to defraud a health care benefit program, 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 a health care benefit program, to wit, Medicare, 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.

(Title 18, United States Code, Sections 1349.)

COUNT TWO
(Health Care Fraud)

3. From at least in or about November 2014 through at least in or about May 2016, in the Southern District of New York and elsewhere, ANTHONY PALMIERI, the defendant, knowingly and willfully did execute, and attempt to execute, a scheme and artifice to defraud a health care benefit program 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, a health care benefit program, namely Medicare, in connection with the delivery of and payment for health care benefits, items, and services, to wit, PALMIERI, in order to fraudulently obtain payments from Medicare to which PALMIERI was not entitled, submitted and caused to be submitted to Medicare numerous claims that falsely represented that certain health care services had been provided to patients.

(Title 18, United States Code, Sections 1347 and 2.)

The bases for my knowledge and the foregoing charge are, in part, as follows:

4. I am a Special Agent with HHS-OIG, and I have been personally involved in the investigation of this matter. This affidavit is based in part upon my conversations with law enforcement agents and others, and my examination of reports and records. Because this affidavit is being submitted for the limited purpose of establishing probable cause, it does not include all of the facts that I have learned during the course of my investigation. Where the contents of documents and the actions, statements, and conversations of others are reported

herein, they are reported in substance and in part, except where otherwise indicated.

Overview of the Fraudulent Scheme

5. From at least in or about November 2014 through at least in or about May 2016, ANTHONY PALMIERI, the defendant, conspired with others to use his company's position as an enrolled participant in Medicare to submit or cause to be submitted to Medicare numerous claims that falsely represented that certain health care services had been provided to patients. As a result of the fraudulent scheme, Medicare paid for services that were never performed.

Overview of the Medicare Program

6. Based upon my training and experience, my participation in this investigation, and my discussions with other HHS-OIG agents, I have learned, among other things, the following regarding the Medicare Program:

a. Medicare is a federal health care program providing benefits to persons who are 65 or older who are entitled to retirement benefits or who are disabled. Medicare is administered by the Centers for Medicare & Medicaid Services ("CMS"), a federal agency under the United States Department of Health and Human Services. Individuals who receive benefits under Medicare are referred to as Medicare "beneficiaries."

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

c. One component of Medicare, referred to as "Part B," covers the costs of physicians' services and outpatient care, such as physical therapy, occupational therapy, and diagnostic tests. Medicare covers these costs only if, among other requirements, they are reasonable, medically necessary, and ordered by a physician.

d. A medical provider must be enrolled in Medicare in order to submit claims to Medicare. In order to enroll in the Medicare program, a medical provider must enter into an agreement with CMS in which the provider agrees to comply with all applicable statutory, regulatory, and program requirements for reimbursement from Medicare. By signing the Medicare enrollment application, the provider certifies that the

provider understands that payment of a claim is conditioned on the claim and the underlying transaction complying with Medicare regulations, Medicare program instructions, and the law, and on the provider's compliance with all applicable conditions of participation in Medicare.

e. A medical provider must obtain a National Provider Identifier ("NPI") before enrolling in Medicare. Once enrolled to participate in Medicare, a medical provider is assigned a Provider Identification Number ("PIN"), also known as a Provider Transaction Access Number ("PTAN"), for billing identification purposes.

f. Under Medicare regulations, a medical provider is permitted to submit claims only for services actually rendered and is required to maintain patient records verifying the provision of services.

g. To receive reimbursement for a covered service from Medicare, a medical provider is required to submit a claim, either electronically or in writing. The claim has to include information identifying the medical provider submitting the claim, the medical provider rendering the service, the referring physician, the patient, and the services rendered. By submitting the claim, the provider is certifying, among other things, that the services were rendered to the patient and were medically necessary.

h. CMS mails patient invoices reflecting Medicare reimbursements paid to medical providers. A particular beneficiary's invoices are directed to that beneficiary's address on file with CMS.

Overview of Independent Diagnostic Testing Facilities ("IDTFs")

i. An independent diagnostic testing facility ("IDTF") is a type of medical provider that is independent both of an attending or consulting physician's office and of a hospital. An IDTF may be a fixed location or a mobile entity. IDTFs typically perform diagnostic procedures referred to the IDTFs by attending physicians.

j. As with other medical providers, IDTFs must apply to and be enrolled in Medicare in order to submit claims for reimbursement to Medicare. In an IDTF's enrollment application to CMS, the IDTF must disclose, among other information, the identity of any person having an ownership, financial, or control interest of five percent or greater, or

any other legal interest in the IDTF. The IDTF must also provide identifying information, such as social security number, date of birth, and licensure, certification, credentialing and hospital employment information, for all non-physician personnel who perform tests, including technicians. If accepted, an enrolled IDTF is required to notify CMS of any changes to the IDTF's enrollment information.

k. All procedures performed by an IDTF must be ordered by the physician or practitioner who is treating the beneficiary, that is, the physician who is furnishing a consultation or treating a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.

The Investigation

7. Based on my review of CMS records, I have learned the following:

a. In or around May 2011, a particular mobile IDTF ("IDTF-1") applied to CMS to participate in Medicare. IDTF-1 listed ANTHONY PALMIERI, the defendant, as the sole individual with an ownership interest and managing control over IDTF-1. IDTF-1 also listed PALMIERI as the sole technician who would perform tests for IDTF-1. PALMIERI signed IDTF-1's application, attesting to the accuracy and completeness of the information contained therein.

b. Also in or around May 2011, PALMIERI signed an electronic funds transfer ("EFT") authorization agreement with CMS, authorizing CMS to direct IDTF-1's Medicare reimbursements to a particular bank account ("Bank Account-1").

c. In or around July 2011, CMS approved IDTF-1's enrollment application and assigned IDTF-1 a particular PTAN.

d. PALMIERI has never notified CMS of any changes to IDTF-1's ownership or to the personnel who performed diagnostic tests for IDTF-1. In particular, PALMIERI never advised CMS that a particular individual ("CC-1") performed diagnostic tests for IDTF-1, or provided CMS with CC-1's identifying information.

8. Based on my interviews with a family medicine doctor (the "Doctor-1"), I have learned the following:

a. In or around September 2014, Doctor-1 began operating a family medicine practice in Queens, New York (the "Family Medicine Practice"). Doctor-1 operated the Family Medicine Practice from in or around September 2014 to in or around May 2015 and again from in or around December 2015 to in or around July 2017.

b. From in or around November 2014 to in or around May 2015, Doctor-1 referred certain patients requiring certain diagnostic tests, including ultrasounds, to IDTF-1.

c. Upon referral of a patient to IDTF-1 by Doctor-1, CC-1 visited the Family Medicine Practice on behalf of IDTF-1.

d. When referring a Medicare beneficiary to IDTF-1 for a test, Doctor-1 or his staff provided CC-1 with information about the patient needed to submit a claim to Medicare for reimbursement for the test ("Patient Billing Information").

e. Although Doctor-1 referred only certain of his patients to IDTF-1, CC-1 asked for and received from one of Doctor-1's medical assistants ("Medical Assistant-1") the Patient Billing Information for other of Doctor-1's patients.

f. Individual-1 was sometimes accompanied by a particular technician ("Technician-1").

g. Beginning in or around June 2015, Doctor-1 began receiving complaints (the "Patient Complaints") from certain of his patients that they had received invoices reflecting payments to IDTF-1 by Medicare for tests that had never been performed, including tests purportedly performed on Doctor-1's patients but purportedly referred to IDTF-1 by a doctor other than Doctor-1 ("Doctor-2") whom Doctor-1's patients had never met.

h. Doctor-1 has not referred any of his patients to IDTF-1 since in or around May 2015.

9. Based on my interview with Medical Assistant-1, I have learned the following:

a. Medical Assistant-1 worked at the Family Medicine Practice from in or around July 2014 to in or around July 2015.

b. Medical Assistant-1 provided CC-1 with Patient Billing Information for patients of Doctor-1 in response to CC-1's statement that he needed such information to determine insurance eligibility.

10. Based on my interviews with Technician-1, I have learned the following:

a. Technician-1 was employed by CC-1 at an imaging company other than IDTF-1 ("Imaging Company-1") from in or around September 2014 to in or around January 2015.

b. During the period Technician-1 worked for CC-1, Technician-1 performed ultrasounds at the Family Medical Practice.

c. The majority of the patients for whom Technician-1 performed ultrasounds at the Family Medical Practice were Medicare beneficiaries.

d. For each ultrasound performed by Technician-1, Technician-1 created a report, which Technician-1 delivered to CC-1.

e. In or around January 2015, CC-1 directed Technician-1 to create fictitious reports for ultrasounds that had never been performed, including reports for patients Technician-1 never saw. Technician-1 stopped working for CC-1 after CC-1 made that request.

11. Based on my interviews with three patients of Doctor-1 ("Patient-1," "Patient-2," "Patient-3," and, collectively, the "Patients"), all of whom were Medicare beneficiaries, and my review of patient invoices (the "Patient Invoices"), patient charts maintained by Doctor-1 at the Family Medical Practice (the "Patient Charts"), and CMS billing records (the "CMS Billing Records"), I have learned the following:

a. The Patient Invoices for Patient-1, who resides in Manhattan, New York, Patient-2, and Patient-3 reflected charges and reimbursements paid to IDTF-1 for tests purportedly referred by Doctor-2 and purportedly performed by IDTF-1 in 2016, such as the following:

i. Medicare paid IDTF-1 approximately $1,593.43 for tests purportedly performed on Patient-1, including an "ultrasound examination of heart" on January 15, 2016; an "ultrasound scanning of blood flow" on January 16,

2016; an "ultrasound scan of veins of both arms or legs" on January 17, 2016; an "ultrasound study of arteries of both arms and legs" on January 18, 2016; an "ultrasound study of arteries and arterial grafts of both legs" on January 19, 2016; and an "ultrasound limited scan of abdominal, pelvic, and/or scrotal arterial inflow and venous outflow" on January 20, 2016.

ii. Medicare paid IDTF-1 approximately $3,579.83 for tests purportedly performed on Patient-2, including an "ultrasound examination of heart" on January 15, 2016; an "ultrasound scanning of blood flow" on January 16, 2016; an "ultrasound scan of veins of both arms or legs" on January 17, 2016; an "ultrasound study of arteries of both arms and legs" on January 18, 2016; an "ultrasound study of arteries and arterial grafts of both legs" on January 19, 2016; and an "ultrasound scan of vena cava or groin graft or vessel blood flow" on January 20, 2016.

iii. Medicare paid IDTF-1 approximately $1,804.61 for tests purportedly performed on Patient-3, including an "ultrasound examination of heart" on February 15, 2016; an "ultrasound scanning of blood flow" on February 16, 2016; an "ultrasound scanning of head and neck vessel blood flow" on February 17, 2016; an "ultrasound scan of veins of both arms or legs" on February 18, 2016; an "ultrasound study of arteries both arms and legs" on February 19, 2016; an "ultrasound study of arteries and arterial grafts of both legs" on February 20, 2016; and an "ultrasound scan of vena cava or groin graft or vessel blood flow" on February 21, 2016.

b. These tests for which Medicare had paid IDTF-1 were never performed on the Patients.

c. The Patients did not recall ever meeting Doctor-2.

d. The Patients did not recognize a photograph of CC-1.

e. The Patient Charts did not reflect the tests for which Medicare had paid IDTF-1.

f. The CMS Billing Records for Patient-1 reflect Patient-1's residence in Manhattan, New York.

12. Based on my review of the CMS Billing Records and my interviews of Doctor-1, I have learned the following:

a. Medicare has paid IDTF-1 approximately $254,784.83 for procedures purportedly referred to IDTF-1 by Doctor-1 on or after June 2015 - that is, after Doctor-1 stopped referring patients to CC-1 or IDTF-1, *see supra* ¶ 8.h.

b. Between on or about December 2014 and on or about May 2016, Medicare paid IDTF-1 approximately $226,848.62 for procedures purportedly referred by Doctor-2 and performed on patients of Doctor-1.

13. Based on my review of bank records for Bank Account-1, I have learned the following:

a. On or about October 28, 2009, ANTHONY PALMIERI, the defendant, opened Bank Account-1 as a business account for IDTF-1.

b. From in or around March 2015 to in or around June 2016, IDTF-1 paid CC-1 and entities associated with CC-1 approximately $842,942.96 from Bank Account-1. Based on my review of the checks from IDTF-1 to CC-1, it appears that PALMIERI signed the checks.

14. Based on my discussions with CC-1[1], I have learned the following:

a. ANTHONY PALMIERI, the defendant, and CC-1 agreed to use the Patient Billing Information to bill Medicare for services that were never performed (the "Agreement").

b. Under the Agreement, PALMIERI would retain approximately 30 percent of amounts fraudulently billed to Medicare, and PALMIERI would pay CC-1 approximately 70 percent of amounts fraudulently billed to Medicare.

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[1] During the course of this investigation, I and other HHS-OIG agents have worked with CC-1. CC-1 has pleaded guilty to federal health care fraud and obstruction offenses and has agreed to assist law enforcement in the hope of obtaining leniency in CC-1's own case. Information provided by CC-1 as part of this investigation has been corroborated by other independent evidence.

WHEREFORE, I respectfully request that a warrant issue for the arrest of ANTHONY PALMIERI, the defendant, and that he be arrested and imprisoned, or bailed, as the case may be.

STEVEN KAY
Special Agent
Office of Inspector General
U.S. Department of Health and Human Services

Sworn to before me this
25th day of June, 2018

HONORABLE KEVIN NATHANIEL FOX
UNITED STATES MAGISTRATE JUDGE
SOUTHERN DISTRICT OF NEW YORK