IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

UNITED STATES OF AMERICA

v.

REGINALD FULLWOOD, JR.

INFORMATION
CRIMINAL NO. 3:24-CR-56-HTW-LGI

18 U.S.C. § 371

The United States Attorney Charges:

At all times relevant to this Information:

GENERAL ALLEGATIONS

The Medicare Program

1. Medicare was a federally funded health insurance program that provided health benefits to individuals who were 65 years of age or older or disabled. Medicare was administered by the United States Department of Health and Human Services ("HHS"), through its agency, the Centers for Medicare and Medicaid Services ("CMS").

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

3. Individuals who qualified for Medicare benefits were commonly referred to as "beneficiaries." Each 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 hospital inpatient care; Medicare Part B covered physicians' services and outpatient care; Medicare Part C covered Medicare Advantage Plans; and Medicare Part D covered prescription drugs.

5. Physicians, clinics, and other health care providers, including laboratories (collectively, "providers"), that provided services to beneficiaries could enroll with Medicare and provide medical services to beneficiaries. Medicare providers were able to apply for and obtain a "provider number." Providers that received a Medicare provider number were able to file claims with Medicare to obtain reimbursement for benefits, items, or services provided to beneficiaries.

6. When seeking reimbursement from Medicare for provided benefits, services, or items, providers submitted the cost of the benefit, item, or service provided together with a description and the appropriate "procedure code," as set forth in the Current Procedural Terminology ("CPT") Manual. Additionally, claims submitted to Medicare seeking reimbursement were required to include: (a) the beneficiary's name and Health Insurance Claim Number; (b) the date upon which the benefit, item, or service was provided or supplied to the beneficiary; and (c) the name of the provider, as well as the provider's unique identifying number, known either as the Unique Physician Identification Number or National Provider Identifier. Claims seeking reimbursement from Medicare could be submitted in hard copy or electronically.

7. Medicare paid for items and services only if they were medically reasonable and necessary, eligible for reimbursement, and provided as represented. Medicare did not pay for items and services that were procured through the payment of illegal kickbacks or bribes.

Medicare Part B

8. Medicare, in receiving and adjudicating claims, acted through fiscal intermediaries called Medicare administrative contractors ("MACs"), which were statutory agents of CMS for Medicare Part B. The MACs were private entities that reviewed claims and made payments to providers for benefits, items, or 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 item or service.

9. Novitas Solutions Inc. ("Novitas") was the MAC for consolidated Medicare jurisdictions JH and JL, which included Louisiana, Mississippi, Oklahoma, Texas, and Pennsylvania.

10. To receive Medicare reimbursement, providers needed to have applied to the MAC and executed a written provider agreement. The Medicare provider enrollment application, CMS Form 855B, was required to be signed by an authorized representative of the provider. CMS Form 855B contained a certification that stated:

> I agree to abide by the Medicare laws, regulations, and program instructions that apply to this supplier. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. 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 and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.

11. In executing CMS Form 855B, providers further certified that they "w[ould] not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare" and "w[ould] not submit claims with deliberate ignorance or reckless disregard of their truth or falsity."

12. Payments under Medicare Part B were often made directly to the providers rather than to the beneficiaries. For this to occur, beneficiaries would assign the right of payment to providers. Once such an assignment took place, providers would assume the responsibility for submitting claims to, and receiving payments from, Medicare.

Medicare Advantage Program

13. The Medicare Advantage Program, formerly known as "Part C" or "Medicare+Choice," provided beneficiaries with the option to receive their Medicare benefits through a wide variety of private managed care plans ("Medicare Advantage Plans"), rather than through Medicare Parts A and B.

14. Private health insurance companies offering Medicare Advantage Plans were required to provide beneficiaries with the same services and supplies offered under Medicare Part A and Part B. To be eligible to enroll in a Medicare Advantage Plan, an individual had to have been entitled to receive benefits under Medicare Part A and Part B.

15. A number of private health insurance companies, including Humana and UnitedHealth Group, contracted with CMS to provide managed care to beneficiaries through various Medicare Advantage Plans. These health insurance companies, through their respective Medicare Advantage Plans, adjudicated claims in locations throughout the United States, and often made payments directly to providers, rather than to the beneficiaries who received the health care benefits, items, and services. This occurred when the provider accepted assignment of the right to payment from the beneficiary.

16. To obtain payment for services or treatment provided to beneficiaries enrolled in Medicare Advantage Plans, providers were required to submit itemized claim forms to the beneficiary's Medicare Advantage Plan. The claim forms were typically submitted electronically and required certain important information, including the information provided in Paragraph 6 of the Information.

17. When providers submitted claim forms to Medicare Advantage Plans, the providers certified that the contents of the forms were true, accurate, and complete, and that the forms were

prepared in compliance with the laws and regulations governing Medicare. Providers also certified that the benefits, items, or services being billed were medically necessary and were in fact provided as billed.

18. The private health insurance companies offering Medicare Advantage Plans were paid a fixed rate per beneficiary per month by Medicare, regardless of the actual number or type of benefits, items, or services the beneficiary received. These payments by Medicare to the health insurance companies were known as "capitation" payments. Thus, every month, CMS paid the health insurance companies a pre-determined amount for each beneficiary who was enrolled in a Medicare Advantage Plan, regardless of whether the beneficiary utilized the plan's services that month. CMS determined the per-beneficiary capitation amount using actuarial tables, based on a variety of factors, including the beneficiary's age, sex, severity of illness, and county of residence. CMS adjusted the capitation rates annually, taking into account each beneficiary's previous complaints, diagnoses, and treatments. Beneficiaries with more illnesses or more serious conditions would rate a higher capitation payment than healthier beneficiaries.

19. Medicare Advantage Plans 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).

Durable Medical Equipment

20. Durable medical equipment ("DME") was reusable medical equipment such as orthotic devices, walkers, canes, or hospital beds. Orthotic devices were a type of DME that included knee braces, back braces, shoulder braces, neck braces, and wrist braces (collectively, "braces").

21. Medicare reimbursed DME providers for medically necessary items and services rendered to beneficiaries. In claims submitted to Medicare for the reimbursement of DME, providers were required to set forth, among other information, the beneficiary's name and unique Medicare identification number, the equipment provided to the beneficiary, the date the equipment was provided, the cost of the equipment, and the name and provider number of the provider who prescribed or ordered the equipment.

22. Medicare would pay claims for the provision of DME only if the equipment was ordered by a licensed provider, was reasonable and medically necessary for the treatment of a diagnosed and covered condition, and was actually provided to a beneficiary.

23. Medicare claims were required to be properly documented in accordance with Medicare rules and regulations. Medicare would not reimburse providers for claims that were procured through the payment of kickbacks and bribes.

24. For certain types of orthotics, such as knee braces billed under HCPCS Code L1833, Medicare required that a provider conduct an in-person examination of a beneficiary and document that examination in the medical record. According to Medicare, knee braces ordered without a documented in-person examination were not medically necessary.

Telemedicine

25. Telemedicine provided a means of connecting patients to providers by using telecommunications technology, such as the internet or telephone.

26. Telemedicine companies provided telemedicine or telehealth 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 received payment from patients who utilized the services of the telemedicine company.

27. Medicare Part B covered expenses for specific telehealth services if certain requirements were met, including that (a) the beneficiary was located in a rural area or a health professional shortage area; (b) services were delivered via an interactive audio and video telecommunications system; and (c) the beneficiary was in a practitioner's office or a specified medical facility—not at a beneficiary's home—during the telehealth service furnished by a remote practitioner.

28. Telehealth services could be covered by and reimbursable under Medicare, but only if telemedicine was generally appropriate, as outlined above, and only if the services were ordered by a licensed provider, were reasonable and medically necessary, and were not procured through the payment of kickbacks and bribes.

The Defendant and Relevant Entities and Individuals

29. **REGINALD FULLWOOD, JR. ("FULLWOOD")**, of Madison County, Mississippi, was the sole owner of BeneMed Holdings, Inc. d/b/a Jackson Medical Supply ("Jackson Medical Supply") and, through a nominee owner, controlled RKE Enterprises LLC d/b/a Sunrise Medical ("Sunrise Medical").

30. Jackson Medical Supply, formed in 2010 and located in Rankin County, Mississippi, operated as a DME supply company.

31. Sunrise Medical, formed in 2018 and located in Madison County, Mississippi, operated as a DME supply company.

32. Individual 1, of Pulaski County, Arkansas, was the nominee owner of Sunrise Medical.

33. SKF Enterprises, LLC ("SKF Enterprises"), formed in 2015 and located in Pasco County, Florida, sold signed doctors' orders for braces to DME supply companies, including Jackson Medical Supply and Sunrise Medical.

34. Co-conspirator 1, of Pasco County, Florida, operated SKF Enterprises.

COUNT 1
The Conspiracy and Its Object

35. Paragraphs 1 through 34 of the Information are re-alleged and incorporated by reference as though fully set forth herein.

36. Beginning in or around August 2016, and continuing through in or around February 2019, in Rankin and Madison Counties, in the Northern Division of the Southern District of Mississippi, and elsewhere, the defendant,

REGINALD FULLWOOD, JR.,

did knowingly and willfully, that is, with the intent to further the objects of the conspiracy, combine, conspire, confederate, and agree with Co-conspirator 1 and others known and unknown to the United States Attorney, to defraud the United States by cheating the United States government or any of its departments and agencies out of money and property, and by impairing, impeding, obstructing, and defeating, through deceitful and dishonest means, the lawful government functions of HHS in its administration and oversight of Medicare and Medicare Advantage.

Purpose of the Conspiracy

37. It was the purpose of the conspiracy for **FULLWOOD** and his co-conspirators to unlawfully enrich themselves and others by, among other things: (a) offering, paying, soliciting, and receiving kickbacks and bribes in return for completed brace orders; (b) shipping and delivering medically unnecessary DME to beneficiaries; (c) submitting and causing the submission

of claims to Medicare and Medicare Advantage Plans, including Humana and UnitedHealth Group, for completed brace orders that were (i) not medically necessary, (ii) obtained through the payment of kickbacks and bribes and therefore not eligible for reimbursement, and/or (iii) not provided as represented; (d) concealing the concealing the offering, paying, soliciting, and receiving of kickbacks and bribes, the shipping and delivering of medically unnecessary DME, and the submission of false and fraudulent claims to Medicare and Medicare Advantage Plans, including Humana and UnitedHealth Group; and (e) diverting fraud proceeds for the personal use and benefit of **FULLWOOD**, his co-conspirators, the use and benefit of others, and to further the fraud.

Manner and Means

38. The manner and means by which **FULLWOOD** and his co-conspirators sought to accomplish the objects and purpose of the conspiracy included, among other things:

a. In or around December 2014, **FULLWOOD** purchased Jackson Medical Supply and thereafter submitted a change of ownership form with Medicare, whereby he certified to Medicare that Jackson Medical Supply would comply with all Medicare rules and regulations, including that it would not knowingly present or cause to be presented a false and fraudulent claim for payment by Medicare, as well as all Federal laws, including the Federal Anti-Kickback Statute.

b. On or about May 4, 2016, **FULLWOOD** sent correspondence to Medicare requesting to add states where items and services were provided by Jackson Medical Supply, specifically seeking to provide off-the-shelf orthoses in 43 additional states other than the State of Mississippi.

c. In or around August 2016, **FULLWOOD** entered into a Personal Services and Management Agreement on behalf of Jackson Medical Supply with SKF Enterprises for SKF

Enterprises to provide "marketing services" to Jackson Medical Supply in order to generate "Leads," when in truth and in fact, as **FULLWOOD** well knew, Jackson Medical Supply was contracting to pay SKF Enterprises kickbacks for fraudulent doctors' orders for DME on a per-order basis.

d. To conceal the kickbacks that **FULLWOOD** and Jackson Medical Supply paid SKF Enterprises for the signed doctors' orders, Co-conspirator 1 and SKF Enterprises generated false invoices to show that reimbursement was per marketing hour, when, as **FULLWOOD** well knew, the reimbursement was per doctor's order. Many of the signed doctors' orders obtained by Jackson Medical Supply from SKF Enterprises were for medically unnecessary braces and other DME.

e. In exchange for the signed doctors' orders, from on or about August 8, 2016, through on or about July 9, 2018, despite knowing that remuneration could not be paid or received for referring beneficiaries for DME, **FULLWOOD**, through Jackson Medical Supply, paid kickbacks in the amount of $1,759,665.00 to Co-conspirator 1, through SKF Enterprises.

f. Additionally, as **FULLWOOD** well knew, Co-conspirator 1 and SKF Enterprises utilized live transfers from telemedicine call centers, ringless voicemail, and inbound telephone calls from paid postcard and television advertisements to generate in-house leads, which were then transmitted to a telemedicine company, which would provide the signed doctors' orders to SKF Enterprises.

g. On or about September 14, 2016, Medicare's National Supplier Clearinghouse conducted a site investigation of Jackson Medical Supply with **FULLWOOD** listed as the authorized representative, and Jackson Medical Supply falsely indicated on the site investigation report that the supplier did not directly solicit (or use third-party vendors to solicit)

beneficiary referrals via telephone.

h. **FULLWOOD**, through Jackson Medical Supply, received multiple complaints from beneficiaries, their family members, and others wherein they reported to Jackson Medical Supply that they did not request the DME received from Jackson Medical Supply and did not need the DME.

i. In many cases, **FULLWOOD** caused beneficiaries to receive multiple braces. For example, in 2018, Jackson Medical Supply submitted to a Medicare Advantage Humana Plan $3,637.49 in claims for dispensing to beneficiary M.O. one back brace, two knee braces, two suspension sleeves, and one shoulder brace.

j. In or around February 2018, Medicare initiated an investigation of Jackson Medical Supply based on data analysis and requested that Jackson Medical Supply submit medical records for a random sample of thirty beneficiaries. On or about July 31, 2018, in response to the Medicare investigation, **FULLWOOD** opened Sunrise Medical in the name of Individual 1 and obtained a National Provider Number by listing Individual 1 as the Authorized Official.

k. In or around October 2018, **FULLWOOD**, through Sunrise Medical, began paying Co-conspirator 1 and SKF Enterprises kickbacks and bribes in exchange for doctors' orders for braces and other DME. From on or about October 5, 2018, through on or about February 1, 2019, despite knowing that remuneration could not be paid or received for referring beneficiaries for DME, **FULLWOOD**, through Sunrise Medical, paid illegal kickbacks in the amount of $55,870.00 to Co-conspirator 1, through SKF Enterprises.

l. From in or around August 2016 through in or around December 2018, **FULLWOOD** caused Jackson Medical Supply to submit approximately $6,984,628.11 in claims to Medicare that were procured by the payment of illegal kickbacks and bribes, were medically

unnecessary, and/or were ineligible for reimbursement. Jackson Medical Supply was reimbursed approximately $3,372,275.61 for supplying medically unnecessary and/or not reimbursable DME.

m. From in or around January 2017 through in or around December 2018, **FULLWOOD** caused Jackson Medical Supply to submit approximately $5,059,423.72 in claims to Medicare Advantage Plans, including Humana and UnitedHealth Group, that were procured by the payment of illegal kickbacks and bribes, were medically unnecessary, and/or were ineligible for reimbursement. Jackson Medical Supply was reimbursed approximately $2,987,372.44 for supplying medically unnecessary and/or not reimbursable DME.

n. From in or around September 2018 through in or around February 2019, **FULLWOOD** caused Sunrise Medical to submit approximately $397,573.49 in claims to Medicare Advantage Plans, including Humana and UnitedHealth Group, that were procured by the payment of illegal kickbacks and bribes, were medically unnecessary, and/or were ineligible for reimbursement. Sunrise Medical was reimbursed approximately $128,444.56 for supplying medically unnecessary and/or not reimbursable DME.

Overt Acts

39. In furtherance of the conspiracy, and to accomplish its objects and purpose, **FULLWOOD** and his co-conspirators committed and caused to be committed, in Rankin and Madison Counties, in the Northern Division of the Southern District of Mississippi, and elsewhere, the following overt acts:

a. In or around August 2016, **FULLWOOD** entered into a Personal Services and Management Agreement on behalf of Jackson Medical Supply with SKF Enterprises for SKF Enterprises to provide "marketing services" to Jackson Medical Supply in order to generate "Leads," when in truth and in fact, as **FULLWOOD** well knew, Jackson Medical Supply was

contracting to pay SKF Enterprises kickbacks for fraudulent doctors' orders for DME on a per-order basis.

b. On or about August 8, 2016, **FULLWOOD**, through Jackson Medical Supply, paid Co-conspirator 1, through SKF Enterprises, $16,250.00 in kickbacks in exchange for doctors' orders for braces and other DME, to be dispensed to beneficiaries and others.

c. On or about October 19, 2016, **FULLWOOD**, through Jackson Medical Supply, paid Co-conspirator 1, through SKF Enterprises, $55,000.00 in kickbacks in exchange for doctors' orders for braces and other DME, to be dispensed to beneficiaries and others.

d. On or about January 9, 2017, **FULLWOOD**, through Jackson Medical Supply, paid Co-conspirator 1, through SKF Enterprises, $75,000.00 in kickbacks in exchange for doctors' orders for braces and other DME, to be dispensed to beneficiaries and others.

e. On or about October 20, 2017, **FULLWOOD**, through Jackson Medical Supply, paid Co-conspirator 1, through SKF Enterprises, $30,550.00 in kickbacks in exchange for doctors' orders for braces and other DME, to be dispensed to beneficiaries and others.

f. On or about December 20, 2017, **FULLWOOD** sent a text message to Co-conspirator 1, stating, "[C]an we have about a dozen Humana 1833 ppo claims. We want to see if they are paying on them. If so, we will take more."

g. On or about April 20, 2018, **FULLWOOD**, through Jackson Medical Supply, paid Co-conspirator 1, through SKF Enterprises, $42,650.00 in kickbacks in exchange for doctors' orders for braces and other DME, to be dispensed to beneficiaries and others.

h. On or about May 4, 2018, Co-conspirator 1 sent a text message to **FULLWOOD**, stating, "Reggie, i just got a message from [SKF Enterprises employee] saying you guys had more issues with Telemed doctors. We are flying back from Jamaica today; at the

airport. I will have to finish handling this tomorrow."

i. On or about July 10, 2018, Co-conspirator 1 sent a text message to **FULLWOOD**, stating, "Reggie, we sent you humana leads today. Should we recall them and send to another DME?" That same day, **FULLWOOD** responded, "Yes please . . . ."

j. On or about September 7, 2018, **FULLWOOD** sent a text message to Co-conspirator 1, stating, "I'm ready for some leads. Can you talk today?"

k. On or about September 11, 2018, Co-conspirator 1 sent an email to **FULLWOOD** and others stating, "Reggie Fullwood and I just had a nice discussion regarding re-engaging with his group on DME orders . . . Reggie's' [sic] group has a new DME opened, which will process only PPO for now. The volume should be 5 patients a day, totaling no more than 35 braces a week. The volume can be Humana and UHC. I already explained to Reggie that we're doing Back, Shoulder, and Wrist ONLY." That same day, **FULLWOOD** responded to the email, stating, "Name Of Company: Sunrise Medical; Name Of Owner: Individual 1 . . . If you need anything else, please let me know."

l. On or about September 14, 2018, SKF Enterprises sent an email to **FULLWOOD** enclosing a link to "today's delivery file," which was a delivery of leads/doctors' orders, which included signed doctors' orders, an Excel spreadsheet with a per brace breakdown, and sometimes a copy of call recordings.

m. On or about October 19, 2018, **FULLWOOD**, through Sunrise Medical, paid Co-conspirator 1, through SKF Enterprises, $10,000.00 in kickbacks for doctors' orders for braces and other DME, to be dispensed to beneficiaries and others.

n. On or about February 1, 2019, **FULLWOOD**, through Sunrise Medical, paid Co-conspirator 1, through SKF Enterprises, $12,600.00 in kickbacks for doctors' orders for

braces and other DME, to be dispensed to beneficiaries and others.

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

TODD W. GEE
United States Attorney

GLENN S. LEON
Chief, Fraud Section
United States Department of Justice