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UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA	:	Hon. Susan D. Wigenton
v.	:	Crim. No. 24-393
RICHARD ABRAZI	:	U.S.C. § 371

INDICTMENT

The Grand Jury in and for the District of New Jersey, sitting at Newark, charges:

(Conspiracy to Defraud the United States and to Offer, Pay, Solicit, and Receive Health Care Kickbacks)

1. Unless otherwise indicated, at all times relevant to this Indictment:

The Defendant

a. Defendant RICHARD ABRAZI was a resident of New York and an owner of Enigma Management Corp., d/b/a "Alliance Laboratories" ("Enigma"), and Up Services Inc., d/b/a "Alliance Laboratories" ("Up"). Enigma and Up were enrolled Medicare providers and submitted claims to Medicare for payment.

Relevant Entities and Individuals

b. "Laboratory Company 1" was a laboratory located in Secaucus, New Jersey. Laboratory Company 1 served as a reference laboratory that performed genetic testing on specimens referred by Enigma and Up.

c. "Co-Conspirator 1" was a resident of New York and a representative of Enigma.

d. "Co-Conspirator 2" was a resident of New York, a licensed nurse practitioner, and an enrolled Medicare provider.

e. "Co-Conspirator 3" was a resident of New York, a licensed physician, and an enrolled Medicare provider.

The Medicare Program

f. The Medicare Program ("Medicare") was a federally funded health care program that provided free or below-cost benefits to certain individuals, primarily the elderly, blind, or disabled. The benefits available under Medicare were governed by federal statutes and regulations. Medicare was administered by the Centers for Medicare and Medicaid Services ("CMS"), a federal agency within the U.S. Department of Health and Human Services ("HHS").

g. Medicare was a "health care benefit program," as defined in Title 18, United States Code, Section 24(b), and a "Federal health care program," as defined in Title 42, United States Code, Section 1320a-7b(f). Individuals who received Medicare benefits were referred to as "beneficiaries."

h. Medicare was divided into four parts: hospital insurance (Part A), medical insurance (Part B), Medicare Advantage (Part C), and prescription drug benefits (Part D). Medicare Part B covered medically necessary physician office services and outpatient care, including laboratory tests.

i. Physicians, clinics, laboratories, and other health care providers (collectively, "providers") that provided items and services to Medicare beneficiaries 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 services provided to beneficiaries.

j. When seeking reimbursement from Medicare for provided benefits, services, or items, providers submitted the cost of the benefit, service, or item provided together with a description and the appropriate "procedure code," as set forth in the Current Procedural Terminology ("CPT") Manual or the Healthcare Common Procedure Coding System ("HCPCS"). Additionally, claims submitted to Medicare seeking reimbursement were required to include: (i) the beneficiary's name; (ii) the date upon which the benefit, item, or service was provided or supplied to the beneficiary; and (iii) the name of the provider, as well as the provider's unique identifying number, known either as the Unique Physician Identification Number ("UPIN") or National Provider Identifier ("NPI"). Claims seeking reimbursement from Medicare were able to be submitted in hard copy or electronically.

k. 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 services rendered and items provided 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 service or item.

l. To receive Medicare reimbursement, providers needed to have applied to the MAC and executed a written provider agreement. The Medicare

provider enrollment application for clinics/group practices and other suppliers, CMS Form 855B, was required to be signed by the provider's authorized official. CMS Form 855B contained a certification that stated:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in section 4A of this application. The Medicare laws, regulations, and program instructions are available through the Medicare Administrative 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, 42 U.S.C. section 1320a-7b(b) . . .).

m. 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."

n. Medicare paid for claims only if the items or services were medically reasonable, medically necessary for the treatment or diagnosis of the patient's illness or injury, documented, and actually provided as represented to Medicare. Medicare would not pay for items or services that were procured through kickbacks and bribes.

o. In certain limited circumstances, Medicare permitted laboratories to establish arrangements with so-called "reference laboratories." Such arrangements existed when a laboratory received a specimen for testing, but instead of testing the specimen in-house, the laboratory acted as a "referring laboratory" by sending the specimen to another laboratory, the "reference laboratory," to complete the testing.

Genetic Tests

p. Cancer genetic tests were laboratory tests that used DNA sequencing to detect mutations in genes that could lead to a higher risk of developing cancer or to assist in the treatment of an existing cancer. Cancer genetic tests were not a method of diagnosing, in the first instance, whether an individual had cancer.

q. In order to have a cancer genetic test performed, an individual typically provided a saliva sample, which contained DNA material ("specimen"). The specimen was then transmitted to a laboratory for testing.

r. DNA specimens were submitted along with laboratory requisition forms that identified the patient, the patient's insurance, and the specific test to be performed. In order for laboratories to submit claims to Medicare for cancer genetic tests, the tests had to be approved by a physician or other authorized medical professional who attested to the medical necessity of the test.

s. Medicare did not cover diagnostic testing, including cancer genetic testing, that was "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." 42 U.S.C. § 1395y(a)(1)(A). Except for certain statutory exceptions, Medicare did not cover "[e]xaminations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury." 42 C.F.R. § 411.15(a)(1).

t. If diagnostic testing was necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, Medicare imposed additional requirements before covering the testing. Title 42, Code of Federal Regulations, Section 410.32(a) provided that "all diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary."

The Kickback Conspiracy

2. From in or around 2018 through in or around March 2024, in the District of New Jersey and elsewhere, the defendant,

RICHARD ABRAZI,

did knowingly and intentionally combine, conspire, confederate, and agree with Co-Conspirator 1 and others known and unknown to the Grand Jury to:

a. defraud the United States by cheating the United States government and any of its agencies and departments out of money and property, and by impairing, impeding, obstructing, and defeating through deceitful and dishonest means, the lawful government functions of HHS and CMS in their administration and oversight of Medicare;

b. violate Title 42, United States Code, Section 1320a-7b(b)(1)(B), by knowingly and willfully soliciting and receiving any remuneration, specifically,

kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, in return for purchasing, leasing, ordering, and arranging for and recommending purchasing, leasing, and ordering any good, facility, service, and item for which payment may be made in whole and in part by a Federal health care program, that is, Medicare; and

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

Goal of the Conspiracy

3. It was the goal of the conspiracy for defendant RICHARD ABRAZI, Co-Conspirator 1, and others known and unknown to the Grand Jury, to unlawfully enrich themselves and others by, among other things, (a) soliciting, receiving, offering, and paying illegal kickbacks and bribes in exchange for ordering laboratory tests, including genetic tests, for Medicare beneficiaries; (b) submitting and causing the submission of false and fraudulent claims to Medicare for services that were ordered and referred through illegal kickbacks and bribes, not medically necessary, ineligible for reimbursement, and not provided as represented; (c) concealing the submission of false and fraudulent claims to Medicare and the receipt and transfer of the proceeds of the fraud; and

(d) diverting proceeds of the fraud for their personal use and benefit, for the use and benefit of others, and to further the fraud.

Manner and Means of the Conspiracy

4. The manner and means by which defendant RICHARD ABRAZI, Co-Conspirator 1, and their co-conspirators sought to accomplish the goal of the conspiracy included, among others, the following:

a. Defendant RICHARD ABRAZI caused to be submitted Medicare enrollment applications on behalf of Enigma and Up in which he certified that Enigma and Up would abide by all applicable Medicare laws, regulations, and program instructions, and that Enigma and Up would not knowingly present or cause to be presented false or fraudulent claims to Medicare, including claims that were procured through the payment or receipt of kickbacks and bribes.

b. Defendant RICHARD ABRAZI, Co-Conspirator 1, and others offered and paid illegal kickbacks and bribes to co-conspirators who ordered and arranged for the ordering of laboratory tests, including genetic tests, for Medicare beneficiaries that Enigma and Up billed to Medicare.

c. Beginning in or around April 2020, during the national emergency and global pandemic caused by the novel coronavirus disease 2019 ("COVID-19"), defendant RICHARD ABRAZI, Co-Conspirator 1, and others gained access to Medicare beneficiaries and their genetic samples by offering COVID-19 tests to Medicare beneficiaries in their homes and at "testing events"

at retirement communities, adult day care facilities, food pantries, churches, senior centers, adult assisted living homes, and other locations.

d. Defendant RICHARD ABRAZI, Co-Conspirator 1, and others caused cancer genetic tests to be ordered for Medicare beneficiaries and billed to Medicare by Enigma and Up even though the following conditions were present: some of the beneficiaries were seeking only COVID-19 testing; the ordering provider was not treating the beneficiaries for cancer, symptoms of cancer, or any other medical condition; the ordering provider did not use the test results in the treatment of the beneficiaries or the management of their care; and the test results were often not provided to the beneficiaries.

e. Defendant RICHARD ABRAZI, Co-Conspirator 1, and others caused Enigma and Up to submit claims to Medicare for laboratory tests, including genetic tests, that were ordered and arranged through illegal kickbacks and bribes, not medically reasonable or necessary, ineligible for reimbursement, and not provided as represented. The genetic tests that Enigma billed to Medicare were performed by Laboratory Company 1 in New Jersey pursuant to a reference agreement with Enigma.

f. Defendant RICHARD ABRAZI, Co-Conspirator 1, and others concealed and disguised the scheme by, among other things: paying illegal kickbacks and bribes in cash; falsely referring to the illegal kickbacks and bribes as payments for rent, loan, or other expenses; falsely indicating in the memo lines of checks that the payments were for consulting, marketing, or advertising;

writing checks to entities owned by co-conspirators; and making payments to co-conspirators' relatives.

g. Defendant RICHARD ABRAZI, Co-Conspirator 1, and others caused Enigma and Up to submit at least $60 million in false and fraudulent claims to Medicare for laboratory tests, including cancer genetic tests, that were ordered and procured through illegal kickbacks and bribes, not medically necessary, ineligible for reimbursement, and not provided as represented. Medicare paid Enigma and Up more than $5 million based on these false and fraudulent claims.

Overt Acts

5. In furtherance of the conspiracy and to accomplish its goal, at least one of the conspirators committed and caused the commission of one or more of the following acts in the District of New Jersey and elsewhere:

a. On or about December 10, 2019, defendant RICHARD ABRAZI paid an illegal kickback and bribe to Co-Conspirator 2 in the form of a check in the amount of $2,000 in exchange for ordering and arranging for the ordering of laboratory tests, including genetic tests, for Medicare beneficiaries referred to Enigma.

b. On or about December 12, 2019, defendant RICHARD ABRAZI paid an illegal kickback and bribe to Co-Conspirator 2 in the form of a check in the amount of $2,000 in exchange for ordering and arranging for the ordering of laboratory tests, including genetic tests, for Medicare beneficiaries referred to Enigma.

c. On or about December 20, 2019, defendant RICHARD ABRAZI paid an illegal kickback and bribe to Co-Conspirator 2 in the form of a check in the amount of $4,000 in exchange for ordering and arranging for the ordering of laboratory tests, including genetic tests, for Medicare beneficiaries referred to Enigma.

d. On or about December 23, 2019, defendant RICHARD ABRAZI, Co-Conspirator 1, and others caused Laboratory Company 1, located in New Jersey, to perform a cancer genetic test for Medicare Beneficiary 1, which Enigma billed to Medicare.

e. On or about May 19, 2020, defendant RICHARD ABRAZI, Co-Conspirator 1, and others caused Laboratory Company 1, located in New Jersey, to perform a cancer genetic test for Medicare Beneficiary 2, which Enigma billed to Medicare.

f. On or about March 1, 2024, defendant RICHARD ABRAZI, through Co-Conspirator 1, paid an illegal kickback and bribe of $6,000 to Co-Conspirator 3 in exchange for ordering and arranging for the ordering of laboratory tests, including genetic tests, for Medicare beneficiaries, and sending laboratory testing orders to Enigma and Up.

g. On or about March 6, 2024, defendant RICHARD ABRAZI and Co-Conspirator 1 offered to pay Co-Conspirator 3 $5,000 in kickbacks and bribes per month in exchange for Co-Conspirator 3 ordering and arranging for the ordering of laboratory tests for Medicare beneficiaries and sending laboratory testing orders to Enigma and Up.

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

FORFEITURE ALLEGATION

1. Upon conviction of the Federal health care offense charged in this Indictment, defendant RICHARD ABRAZI shall forfeit to the United States, pursuant to 18 U.S.C. § 982(a)(7), all property, real or personal, the defendant obtained that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of such offense.

Substitute Assets Provision

2. 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 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 which cannot be subdivided without difficulty,

it is the intent of the United States, pursuant to 21 U.S.C. § 853(p), as incorporated by 18 U.S.C. § 982(b), to seek forfeiture of any other property of defendant RICHARD ABRAZI up to the value of the forfeitable property described above.

A True Bill

[redacted]

Foreperson

Philip R. Sellinger

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CASE NUMBER: **24-cr-393**

United States District Court
District of New Jersey

UNITED STATES OF AMERICA

v.

RICHARD ABRAZI

INDICTMENT FOR

18 U.S.C. § 371

A True Bill,

[redacted]

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